Behavioral Health and Recovery Services
Jenine Miller, Psy.D., Director of Health Services
Providing Mental Health and Substance Use Disorders Treatment Services

***Ukiah Offices*: 1120 S. Dora St. • Ukiah • CA • 95482 • (707) 472-2300 • FAX (707) 472-2306**
***Fort Bragg Offices*: Avila Center • 790-B S. Franklin St. • Fort Bragg • CA • 95437 • (707) 961-2665 • FAX (707) 961-2698**
***Willits Integrated Services Center*: 125 E. Commercial St. • Willits • CA • 95490 • (707) 456-3850 • FAX (707) 456-3808**

APPLICATION FOR SERVICES & CONSENT TO TREATMENT

I,_____, hereby make application to receive care and treatment voluntarily from Mendocino County Behavioral Health & Recovery Services (MCBHRS), Mental Health Program. I understand that such care and treatment may consist of an evaluation process, psychotherapy and, in some instances, medication.

If this application is accepted, MCBHRS, Mental Health Program is authorized to administer treatment. My consent, however, does not waive my civil rights. I reserve the right to decline treatment. I understand that I have the right to an explanation of treatment to be administered, and that I may voice dissatisfaction by contacting the MCBHRS, Mental Health Program Patients' Rights Advocate at (800) 970-5816.

I further understand that my records, that may be stored and transmitted electronically, are confidential and will not be released to outside individuals or agencies without my expressed written consent. However, I realize that information may be released without authorization under the following circumstances:

1. To qualified professionals in order to provide services to me.
2. Upon the filing of a conservatorship.
3. To make a claim for medical assistance or insurance on my behalf.
4. Upon the receipt of a legitimate subpoena or court order.
5. To law enforcement agencies, if the information is relevant to a threat made to a federal or state official or their families.
6. In the event of a valid medical emergency.
7. If the information is relevant to the investigation of an allegation of child abuse or elder abuse has occurred.
8. When a physical threat against another person requires disclosure.
9. As required by law for the administration of justice.

Your Rights Regarding Electronic Health Information Exchange:

We participate in the electronic sharing of health information with other health care providers, health plans, other health care related entities, and others, through SacValley MedShare, a health information exchange (HIE). Your electronic health records, including certain sensitive health information, e.g., mental health information, HIV/AIDS, genetic

information, some alcohol and drug abuse treatment information, communicable diseases, and developmental and intellectual disability treatment, may be accessible through the HIE to properly authorized users for purposes of treatment, payment, and health care operations, as well as other purposes permitted or required by law unless you submit an opt-out request online through www.sacvalleyms.org.

If you do not want your electronic health records shared and used through the HIE, you can opt-out of the HIE by submitting your opt-out request online at www.sacvalleyms.org.

Even if you opt-out of having health information used and disclosed through the HIE, some of your information may still be available through the HIE to properly authorized individuals as necessary in an emergency, Prescription Drug Monitoring Program, or to report specific information to a government agency as required by law (for example, reporting of certain communicable diseases to suspected incidents of abuse).

I understand and agree that I was offered free language assistance and understand that I have a right to such assistance at any time during my treatment.

I understand and agree to the above conditions in order for treatment to be received.

Signature:_____ Date:_____
(Client/Parent/Conservator/Guardian)
Signature:_____ Date:_____
(Witness/Staff)

Consent must be signed by the client, parent or nearest relative available or guardian if the client is a minor or physically or mentally incompetent. Complete the following if client does not sign:

_____ _____
Reason Client is unable to Sign Date

_____ _____
Parent or Relative or Guardian Signature Relationship

NOTE TO STAFF: At time of signing this document client should also sign HIPAA receipt and UMDAP.

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ACKNOWLEDGMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES AND OTHER INFORMATION

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Mendocino County Behavioral Health & Recovery Services (BHRS), Mental Health Department. This Notice of Privacy Practices provides information about how BHRS may use and disclose your protected health information (PHI), including electronically stored PHI, and your rights to your medical file and other important information. Please read Notice of Privacy Practices in full.

In addition to receiving our Notice of Privacy Practices, you are also being provided with the following information:

- MHP Provider List
- Guide to Medi-Cal Mental Health Services Booklet
- Mental Health Plan Members Brochure
- Your Right to Make Decisions About Medical Treatment (Advance Directive) Brochure
- Grievance and Appeal Process Brochure
- Request for Change of Provider Brochure
- Request for a Second Opinion Brochure
- Patients' Rights Advocacy
- Medi-Cal Notice of Privacy Booklet

Mendocino County Mental Health Plan (MHP) offers free Language Line Interpreter assistance and TTY/TDD services for beneficiaries requesting or accessing services. These services may be requested at any Mental Health Plan Provider site or by calling 1-800-555-5906. **By signing you are acknowledging you were offered Interpreter Services at no cost to you.**

If you have any questions about any of the above information, please contact:

Mendocino County Behavioral Health & Recovery Services
Mental Health Program
1120 South Dora Street
Ukiah, CA 95482
(707) 472-2300 FAX: (707) 472-2306

Acknowledgment of Receipt:

Signature:_____Date:_____
(Client/Parent/Conservator/Guardian)

Inability to Obtain Acknowledgment: Describe the efforts made to obtain Acknowledgment and the reasons why it was not obtained:

_____

_____

Signature of Provider Representative:_____ Date:_____

NOTE: Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at https://www.mendocinocounty.gov/departments/behavioral-health-and-recovery-services/mental-health-services or contacting our reception office in Ukiah at (707) 472-2300 or Fort Bragg at (707) 961-2665.