Consent for Treatment and Maintenance of Records for a Minor

Family & Children Services of Silicon Valley: A Division of Caminar (CAMINAR/FCS), a private, nonprofit organization, is committed to providing professional counseling services and is contracted by your child’s school district to provide this service to your child. Please review the following important information and then initial each line.

______ Confidentiality: The counselor-client relationship is confidential. Your child’s presence and all that your child says during counseling is held in strict confidence. As legal guardian, you may release the counselor from the obligation of confidentiality by signing a waiver. You have the right to sign or not sign such a waiver. According to California law, counselors are mandated reporters and must breach confidentiality under the following circumstances when there is a reasonable suspicion of:
1. An incident of child abuse, past or present.
2. An incident of elder abuse or dependent adult abuse.
3. Serious threat of harm to oneself or others.

______ Acknowledgement of Notice of Privacy Practices: Attached to this consent form, please find the CAMINAR/FCS Notice of Privacy Practices, which provides you with information about how we may use and disclose protected health information about your child. In addition to the copy we are providing to you, the notice is available by accessing our website at www.fcservices.org.

______ Acknowledgement that my child’s art work (drawings, collage, clay work, etc.) may be used as part of clinical training. Counseling staff members meet for consultation/supervision with licensed clinicians and may use a client’s artwork in the course of their training. I give my permission for this to occur.
I, _________________________________, as __________________, Parent/guardian name Relationship to minor

have the legal authority to consent for psychological treatment for

________________________________________.

Name of minor

I have read the above informed consent information and understand it. I hereby give my consent for treatment by CAMINAR/FCS and agree to the maintenance of records by CAMINAR/FCS.

________________________________________

Signature of parent, legal guardian, conservator, or adult student

____________________

Date

____________________

Witnessed by
FAMILY AND CHILDREN SERVICES: A Division of CAMINAR (CAMINAR / FCS)
Consent for Group Counseling and Maintenance of Records for a Minor

CAMINAR/ FCS, a private, non-profit organization, is committed to providing professional counseling services and is contracted by your child’s school district to provide group counseling service to your child.

GROUP COUNSELING

Group counseling can be a powerful and valuable venue for self-esteem building and growth. In order for your child to reap the benefits of group counseling groups are structured to include the following elements:

- A safe environment in which your child is able to feel respected and valued as he/she works
- An understanding of group goals and group norms
- Members of group should remember that keeping confidentiality allows for an environment where trust can be built and all members may benefit from the group experience

Confidentiality: The therapist is bound by law to maintain confidentiality. Your child’s presence and all that your child says in group therapy is held in strict confidence. Records will include only your child’s personal progress in group—not information about other group members. As legal guardian, you may release the therapist from the obligation of confidentiality by signing a waiver. You have the right to sign or not sign such a waiver. According to California law, therapists are mandated reporters and must breach confidentiality under the following circumstances when there is a reasonable suspicion of:

1. An incident of child abuse, past or present.
2. An incident of elder abuse or dependent adult abuse.
3. Serious threat of harm to oneself or others.
Acknowledgement of Notice of Privacy Practices: Please find the Family and Children Services Notice of Privacy Practices which provides you with information about how we may use and disclose protected health information about your child. Copies of this notice are also available by accessing our website at www.fcservices.org

Acknowledgement that my child’s art work (drawings, collage, clay work, etc.) may be used as part of clinical training. Therapeutic staff meet for consultation/supervision with licensed clinicians, and may use client’s art work in the course of their training. I give my permission for this to occur.

I, ________________________________, as __________________________
(parent/guardian name) (relationship to minor)

have the legal authority to consent for group counseling for

______________________________
(name of minor)

I have read the above informed consent information and understand it. I hereby give my consent for group counseling services by Family and Children Services and agree to the maintenance of records by Family and Children Services.

______________________________
(signature of parent, legal guardian, conservator, or adult student)

______________________________
(date)
Authorization to Use and Disclose Health Information

To the clients of Family & Children Services of Silicon Valley (FCS):

- It is our policy to hold all information received from you or about you in the strictest confidence and not to obtain or provide any such information without your written permission unless otherwise noted in our Notice of Privacy Practices. This form is for the purpose of enabling you to authorize an exception to our confidentiality policy. You have the right to limit the information exchanged as indicated below and to request a copy of this Authorization.

- If you wish to revoke this Authorization before it expires, or before you stop receiving direct services from Family and Children Services, you must request that revocation in writing as per California Civil Code 56.11 and HIPAA regulations to the Director of Programs and Services at 375 Cambridge Avenue, Palo Alto, CA 94306. You understand that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received.

- You understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California law. However, if the disclosure consists of treatment information about a client in a federally-assisted alcohol or drug abuse program, federal law prohibits the Recipient from making any further disclosure of such information unless expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

- You understand that you may refuse to sign this Authorization and that your refusal will not affect your ability to obtain treatment (or payment, if applicable) from Family and Children Services. Except when you are (i) receiving health care solely for the purpose of creating information for disclosure to a third party (ii) the lack of disclosure would prevent appropriate treatment.

I hereby authorize ______________________________

to exchange confidential information with ______________________________
in regard to ______________________________
The specific information must be limited to the following:

- [ ] Diagnosis
- [ ] Pertinent summary of psychosocial and psychiatric history
- [ ] Medical information, including medical test results
- [ ] Other:
  
  __________________________________________
  __________________________________________

The information must be used for the purpose of ____________________________
and excludes the following: _______________________________________

  __________________________________________
  __________________________________________

This Authorization is valid only for the period of time which you are receiving direct services from FCS, or until this date: _______________________

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of the health information.

______________________________________
Signature of Client

________________________
Date

______________________________________
Print Name of Client

________________________
Date

______________________________________
Signature of Parent, Guardian or Conservator, if applicable

________________________
Date

______________________________________
Signature of Witness

________________________
Date
NOTICE OF PRIVACY PRACTICES (N OPP)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information, including mental health information, developmental disability information and substance abuse treatment records. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9-30-13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices as long as it complies with applicable law. If we make any material revision to this Notice, we will post a copy of the revised Privacy Notice in each of our offices which will specify the date on which the revised Notice is effective. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

This section describes different ways that we might use and share/disclose your PHI. Not every use and disclosure in a category will be listed, but all of the ways we are permitted to use and share your PHI do fall into one of the categories described below.

We may use and disclose your health information without your consent for the following purposes:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you both within our program and to other providers. For example, we may use or disclose your health information to provide patient-related communications such as telephoned-in prescriptions.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Quality and Licensing: We may use and disclose your health information in connection with required operational activities such as reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use or disclose your health information when we are required by law to do so. For example, we must report certain crimes and to law enforcement and we may also disclose your health information in response to a valid court order or in connection with conservatorship proceedings or by request of state advocates and government agencies in some circumstances.

Health and Safety: We may use and disclose your health information for your health and safety and the safety of others. For example, we may provide information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. In some instances, we may also provide identification information to law enforcement upon your disappearance. Substance abuse information protected by federal law (42 U.S.C. §290dd-2; 42 CFR Part 2) may be disclosed only to report a crime on our premises, crimes against our personnel, or to report child abuse or neglect.

Government and Law Enforcement: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. We may also disclose your information to county social workers, probation officers, or other persons legally authorized to coordinate health care services on your behalf. However, we will only disclose substance abuse treatment information protected by federal law (42 U.S.C. §290dd-2; 42 CFR Part 2) in response to a legally compliant court order.

We may also use and disclose your information as follows:

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so in writing.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person designated by you that is responsible for your care, upon their request, of your serious illness, injury or death unless you ask that this information is not provided. Substance abuse information protected by federal law (42 U.S.C. §290dd-2; 42 CFR Part 2) will not be provided without your authorization unless to your legal representative in an emergency situation.

We will obtain your consent to disclose your psychotherapy notes (in most cases), sell your PHI, use your PHI for fundraising purposes and to otherwise use your PHI for marketing purposes, (if allowed by state and federal law) other than providing treatment options, and providing you with information regarding our related benefits and services. We will obtain your consent in accordance with state and federal law before we use and/or disclose your PHI in a way that is not described in this Notice. We may require your authorization to disclose information upon your request in some instances. You may revoke your authorization at any time. Such revocation will not apply to any action that we took in reliance on your authorization prior to the revocation’s receipt.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically and reasonably do so. You must make a request in writing to obtain access to your health information. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our contractors disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years or such shorter time as you may specify. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions (except to the extent required by law for certain cash transactions), but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location,
and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Breach Notification.** We will notify you as required by law following a breach of your unsecured health information.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. Violations of federal law (42 U.S.C. §290dd-2; 42 CFR Part 2) protecting substance abuse information is a crime; suspected violations may be reported to the US Attorney’s Office by calling (408) 535-5061. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services or the US Attorney’s Office.

**CONTACT INFORMATION**

Quality Management
950 W. Julian Street
San Jose, CA 95126
Phone: (408) 292-9353
FAX: (408) 287-3104
NOTICE REGARDING TREATMENT BY AN INTERN

Your assessment and treatment at Caminar/Family and Children Services (FCS) will be provided by_______________________, who is an MFT/PCC/SW Associate and is working at Family and Children Services as part of clinical training. When the internship is completed, ___________________ will be eligible to apply for licensure as an LMFT, LPCC, or LCSW in the State of California.

During their internship at Caminar/FCS, ____________________ is being supervised by Maritza Henry, a Licensed Marriage and Family Therapist in the State of California (License # MFT 38496). Your therapist will be consulting with Mrs. Henry about your treatment.

If you have any questions about this process, please discuss these with your therapist.

_________________________________________________________        ____________________________
Client’s Signature              Date

_________________________________________________________       ____________________________
Parent/Guardian's Signature            Date

_________________________________________________________   ____________________________
Therapist’s Signature            Date
Client Litigation Agreement

Therapist/Agency will not voluntarily participate in any litigation or custody dispute in which Client and another individual or entity are parties. Therapist/Agency has a policy of not communicating with Client’s attorney and generally will not write or sign letters, reports, declarations, or affidavits to be used in Client’s legal matter. Therapist/Agency will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist/Agency for any time spent for preparation, travel, or other time in which Therapist/Agency has made him/herself available for such an appearance at a prorated fee based on the Agency’s customary hourly rate of $250.00.

I have read and understand the terms of this Agreement.

____________________________________  _________________________
Signature of Client             Date

____________________________________  _________________________
Name of Client (Printed)         Date

____________________________________  _________________________
Signature of Parent, Guardian or Conservator  Date

____________________________________  _________________________
Signature of Witness      Date