CONSENT FOR SERVICES

The undersigned client* or responsible adult** consents to and authorizes mental health services by **Psychiatric Wellness Center Inc. (PWC)**.

These services may include psychological testing, psychotherapy/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at a different location, services provide within the PWC mental health system will be coordinated by the staff of a single agency. The undersigned understands:

1. He/she has a right to be informed of and participate in the selection of any of the above services provided.
2. He/she has a right to receive any of the above services without being required to receive other services from the PWC mental health system.
3. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or withdraw this consent at any time.
4. All personnel of the agency, as a condition of their employment, annually sign an oath of confidentiality which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures.
5. Any information disclosed to staff which is determined by them to be important to care, will be recorded in the clinical record to ensure treatment staff have available the most complete information about the client when decided on treatment appropriate to the client's needs and for quality of care.
6. All client names are entered into a computer-based information system that identifies the program(s) that is/are providing services to the client. This information is available without client authorization to any workforce member of PWC directly-operated or contract service agency system.
7. Information from a client's clinical record relative to service delivery needs may be shared within this agency and within the PWC mental health system (directly-operated and contract agencies) without obtaining the authorization of the client.

Consent for Email

To use secure email to communicate with me for the following purposes:

- Scheduling appointments
- Sending reminding of appointments and/or treatment instructions
- Relaying factual mental health information that was previously discussed with me.

The undersigned understands:

1. Email should never be used for emergency purposes. The email system does not have a 24-hour monitoring services nor can the system guarantee delivery of email messages in a timely manner. In the care of an emergency, please dial 911.
2. Consenting to the use of secure email is at the undersigned's request.
3. Email will never be used for diagnostic or treatment purposes and requests to be assessed or treated through email will not be honored.
4. Email is not an instant messaging system. There will likely be a delay, up to several days, between the time I submit an email and the point at which my treating provider reads and responds to the email. I will not know if the information I the email has been seen, and I cannot anticipate when I will receive a response.
5. By signing this consent, I agree to allow the Psychiatric Wellness Center staff to send information about my mental health condition and care via secure email.
6. Information sent via email may assist mental health staff in treatment and scheduling.
7. The ability to use email may be rescinded by me or mental health staff at any point in which I or mental health staff believe email is not the most appropriate means of communication for me.
8. Any authorized use of email should be reported to mental health staff as soon as possible.
9. Although the email will be sent through a secure means, there is a risk that an email intended for me may be inadvertently sent to the wrong email address.

I have read this document carefully and understand the above information. By signing below, I acknowledge and consent to use of email for communication for the purposes described above.

Email Address:_____

_____ _____

Signature of Client Date

_____ _____

Signature of Responsible Adult Date

*A minor client receiving services under his/her own signature must have the signed Consent of Minor form on fil in the clinical record.
**Responsible Adult – Guardian, Conservator, Parent of minor when required.