INFORMED CONSENT FOR COUNSELING, MENTAL HEALTH SERVICES, AND MEDICATION MANAGEMENT

Counseling and Mental Health Services (CMHS)
377 Mansfield Road, Unit 1255 Storrs, CT 06269-1255
Telephone: 860.486.4705 Fax: 860.486.9159
Website: www.counseling.uconn.edu

Services and Staff. I understand that the University of Connecticut Counseling and Mental Health Service is a professional agency offering counseling, mental health, and medication services, and that these services are provided by licensed mental health professionals or graduate students under their supervision. In all cases, graduate students in training are supervised by a licensed mental health professional that will have access to my information to facilitate supervision sessions and provide consultation to ensure the quality of my care. In addition to providing direct clinical services, this agency also provides training, professional consultation, and engages in research.

Confidentiality and Information Disclosure. I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside the CMHS without my written permission. Information from this record will be released only as described herein as authorized by my written consent, and/or as otherwise authorized by law.

I UNDERSTAND THE EXCEPTIONS LISTED BELOW.

1. **Imminent Threat to Health or Safety.** If CMHS staff believe that there is a substantial risk that I will, in the near future, (a) cause serious harm to myself or others, or (b) suffer serious harm due to grave disability including a lack of capacity to protect myself from harm or to provide for my basic needs, CMHS staff must take action to protect me and/or my intended victim(s). These steps may include: (1.) seeking hospitalization for me; (2.) informing my parent or caregiver; (3.) notifying law enforcement officers; (4.) notifying the University of Connecticut Care Team; (5.) notifying the intended victim(s) (if applicable).

2. **Collaboration with the Care Team.** I understand that the University is required by law to have a trained threat assessment team. I understand that there are times when CMHS will share such information when, in an effort to ensure the safety of the University and its community members, including myself, CMHS deems such limited sharing of information advisable.

3. **Adult with Intellectual Disabilities and the Elderly.** If CMHS has reason to suspect that an adult with intellectual disabilities and/or an elderly individual is abused, neglected, or exploited, CMHS is required by law to immediately make a report and provide relevant information to the Connecticut Department of Social Services.

4. **Child Abuse.** If CMHS has reason to suspect that a child is abused or neglected, CMHS is required by law to report the information available to the Connecticut Department of Children and Family Services.

5. **Judicial or Administrative Proceedings.** If I am involved in a court proceeding and a request is made for information about my diagnosis, treatment, and/or medical record, such information is privileged under state law, and CMHS will not release information without my written authorization or the written authorization of my legal representative, or as may be required by law. If you file a complaint against a CMHS staff member, relevant information may be disclosed to those receiving or responding to the complaint, including the Vice President of Student Affairs and University legal counsel, and as otherwise permitted by law.

6. **Collaboration with Student Health Services.** I understand that CMHS is a division within the oversight of the University of Connecticut Student Health Services (SHS). SHS providers serve as the first point of contact during evening and weekend shifts when the CMHS office is closed. For the intended purpose of coordinating my care in the event that I require an urgent or emergent CMHS on-call response, SHS staff will have access to my basic appointment, scheduling, and medical information. SHS staff cannot access the content of my psychotherapy notes. If broader access is deemed necessary for CMHS staff to ensure my continuity of care, I will be asked to sign a release of information document allowing CMHS to release and/or obtain information on my behalf.

7. **Health Oversight:** Certain Connecticut Health Boards have the power, when necessary, to subpoena relevant records should a CMHS staff member be the focus of an inquiry. CMHS staff may be required to report to the appropriate Connecticut Board if CMHS receives information that another mental health provider is engaging in illegal or unethical practices.

Payment for Services. I understand that CMHS utilizes a fee-for-service model that requires billing, collection, and health insurance claims processing. CMHS, or a business associate, will have limited access to my health information for billing purposes, including contact with my insurer to verify what benefits I am eligible for, to obtain prior authorization, and to receive payment from my insurance carrier. My health insurance company may send an Explanation of Benefits (EOB) to the policy holder or person responsible for paying the bill. This document will include an explanation of services and charges, but will not contain clinical information.

Electronic Mail. I am cautioned that electronic mail (e-mail) is not a confidential means of communication. CMHS cannot ensure that e-mail messages will be received or responded to if my provider is unavailable. I understand that e-mail is not the appropriate way to communicate confidential, urgent, or emergency information. I understand that I am encouraged to
come to CMHS or contact the office directly by calling 860-486-4705 during open office hours. If I have urgent or emergent clinical need when the CMHS office is closed, I will contact the SHS Advice Nurse at 486-4700 and/or phone the University of Connecticut Police Department at 911 (if emergency).

**Digital Recording.** I understand that my interviews may be recorded using a webcam for the purpose of continued staff training and clinical supervision. The recordings are treated confidentially and are deleted after they are used. Any concern I have about recording will be addressed by my provider. I will never be recorded without my permission.

**Risks and Benefits.** I understand that there is a possibility of risk and benefit which may occur with clinical intervention offered by CMHS. Counseling, Mental Health Services, and Medication Management may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. CMHS services can impact relationships with significant others. The benefits from CMHS services may be an improved ability to deal with everyday stress. Taking personal responsibility for working with these issues may lead to greater personal growth. I understand that medication use may also be helpful in my care or may produce negative or unwanted side effects.

**Eligibility, Appropriateness, and Referrals.** I understand that my eligibility for service at CMHS is contingent upon my status as an enrolled UCONN (Storrs Campus) student. The delivery of services from this agency to me is also contingent upon whether the CMHS staff and I can agree that the services are appropriate given the needs and conditions I present. If it is decided that CMHS is not the appropriate agency to meet my needs, or if I require an alternate level of care, I understand that I will be given referrals to resources more appropriate to my needs and goals.

I understand that services will be provided by licensed professionals or graduate students in training under their supervision. I have read and understood the above and I consent to participate in the evaluation and treatment offered by Counseling and Mental Health Services. I hereby knowingly consent to the release of my information as described herein. I will abide by the procedures outlined and will bring forward any issues I may have regarding this informed consent document and treatment. I understand that I may stop treatment at my discretion.

**I AM EXPRESSLY ACKNOWLEDGING AND AGREEING TO THE CONFIDENTIALITY AND DISCLOSURE INFORMATION OUTLINED ABOVE.**

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<tr>
<th>Yes</th>
<th>No</th>
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**In the event that I become potentially dangerous to myself or others, I am listing this person as my initial emergency contact.**

<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
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<tbody>
<tr>
<td>Relationship</td>
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<td>Phone</td>
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Patient Name (please print): ______________________________________________________

Signature:  

______________________________