CONSENT TO TREAMENT & SERVICE

(Please Initial below)

____ I understand that health care is not an exact science and that no guarantees are made concerning the course of treatment proposed by my provider. If I have questions about benefits and risks of available options, I should be directed to the treatment staff.

____ I understand that as part of my treatment, I have a responsibility to participate in my care, including taking medications as prescribed, participating in the development of my treatment care, and wellness plan.

____ I understand that this plan will be done in accordance with PGST tribal, federal and state laws.

____ I understand that my providers will depend on my statements, including statements about my medical history, to help with evaluation and treatment. I also understand that the evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

____ I understand that I have a right to a copy of all consents I sign.

____ I understand that I may terminate my service from PGST Health Services Department programs at any time.

____ I understand that persons seeking drug and alcohol related services are subject to special policies established by the federal government concerning access to medical records, requesting the correction or removal of information from the record or appealing a decision limiting access to the record.

Acknowledgement

By signing this form, (parent or legal guardian, if required), I agree that I have read or had this consent form read to me, that I understand it and that I have the opportunity to ask questions. I agree to be truthful in providing information. I acknowledge that I have received the following documents and have had them read or explained to me as well: (Please initial Below)

____ The Patient Rights – which describes my rights during treatment, and
____ The Notice of Privacy Practices – which explains how information about me will be used.

I hereby ask and agree to evaluation and treatment for myself and/or my child(ren). I hereby consent to participate in treatment, care and services at PGST Health Services.

____ ______________

Signature of Person Served OR Signature of Guardian/Responsible Person Date
(if under 14 years of age and primary diagnosis is MH)

____

Print Patient Name

____ ______________

Signature of Witness Date

Approved by Health Services Advisory Committee 4/2019

CONSENT TO SHARE INFORMATION

I agree to allow my Port Gamble S'Klallam primary care, dental, and behavioral health providers to share health information about me as needed for the purpose of planning and coordinating my health care. Coordinating physical, dental, and emotional health information helps ensure I have access to the most effective treatments available, helps my providers understand me better and avoid unnecessary tests and dangerous medication interactions.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the Health Clinic Administrator.
- This authorization is giving the Port Gamble S'Klallam primary care, dental, and behavioral health programs the right to discuss my medical information with one another.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and the PGST will not condition treatment or payment on my providing this authorization.

By signing this form, (parent or legal guardian, if required), I agree that I have read or had this consent form read to me, that I understand it and that I have the opportunity to ask questions.

____ __________
Signature of Person Served OR Signature of Guardian/Responsible Person Date
(if under 14 years of age and primary diagnosis is MH)

____ __________
Signature of Witness Date