SECTION VII – CONSENTS AND AUTHORIZATION STANDARDS FOR CLIENT ACCESS TO HEALTH INFORMATION AND USE/DISCLOSURE OF HEALTH INFORMATION

CONSENTS

It is the responsibility of network providers to ensure compliance with minimum requirements in obtaining client consent for specialty mental health services. Copies of the Local Mental Health Plan (LMHP) consent forms are at the end of this section for your reference in developing your own unique forms. It is important to ensure that all the required information is included on your consent forms and that they do not include a reference to the LMHP.

Form deficiencies identified during reviews are frequently the result of the absence of required information. The minimum content for consents is included in this section to assist you with ensuring compliance when developing a unique form.

The following types of consents must be included in a Medi-Cal beneficiary's clinical record:

- *Consent for Services* form (includes the Consent of Minor) *MH 500 in English* (Attachment I) https://file.lacounty.gov/SDSInter/dmh/1135786_MH500ConsentforServices.pdf or *Spanish* (Attachment II) https://file.lacounty.gov/SDSInter/dmh/1143559_MH500ConsentforServices-Spanish.pdf
- *Consent for Telehealth Services* Refer to: DMH Provider Bulletin, Sixth Edition, Issue 5, Rev. June 2020.
- *Informed Consent for Psychotropic Medication* when appropriate; and
- *Consent for an Appeal* for services rendered on behalf of the beneficiary shall require the beneficiary's signed consent.
- Notice to clients stating where they can file a complaint (AB 630, Chapter 229, Statutes of 2019) For more information, you may contact the board online at: www.bbs.ca.gov
  Refer to: DMH BULLETIN, FFS II, Eighth Edition, Issue 1, September 2020.

CONSENT FOR SERVICES

DEFINED

This process documents the Medi-Cal beneficiary's agreement to receive specialty mental health services, the mental health services provided, instructions and client rights. A *Consent for Services* (includes Consent of Minor) form must be signed during the first contact with a client and remains in effect for the course of treatment

MINIMUM CONTENT REQUIRED

- Client Name
- Name of individual, group, or organizational network provider
- Type of Services Provided:
  - ♦ List in specific language the type of service(s) that may be delivered, such as an assessment, psychological testing, psychotherapy, medication, laboratory tests, and/or diagnostic procedures.

- General Information:
  - The client has a right to be informed and participate in the selection of treatment services;
  - Treatment services are voluntary;
  - The client may request a change of service provider (agency or treating clinician); and
  - The information contained in the clinical record may be released to any LMHP operated or contracted agency or provider, pursuant to Welfare and Institutions Code Section 5328, without obtaining the consent of the client.
- Signatures Required:
  - For adults: Client signature and date, or indication on the form if the client is unable/unwilling to sign the *Consent for Services* form.
  - For minors: Signature of responsible adult, relationship to client, and date.
  - For clients unwilling to sign or a minor signing without parental consent: A witness statement (which may be by the clinician) explaining the absence of the client signature with the witness' signature and date.
  - For translators: Translator signature and date.

- Additional Requirements for *Consent of Services* form:
  - Affirmation that the Consent of Minor has been completed for under-aged child or adolescent;
  - Printed client name and the DMH Client ID number;
  - Confidentiality and disclosure statement; and
  - Date when the client or responsible adult was given or declined a copy of the *Consent for Services* form.

CONSENT OF MINOR

DEFINED

This process documents the right of a minor, under the age of 18, to consent to services without parental consent. This can occur only when one of the following special circumstances exists:

- Emancipated: only a court can decide this status;
- Self-sufficient: client must be at least 15 years of age, living apart from the parent or guardian (with or without their consent), and managing his/her own affairs;
- Military: client currently on active duty;
- Married: client currently or formerly married; or
- In need of mental health services:
  - client must be at least 12 years of age and mature enough to participate in the services provided;
  - there must be a danger of serious physical or mental harm if services are not provided or there is alleged incest or child abuse;
  - there is documentation that the parent(s)/guardian(s) were contacted or the reason why they were not contacted;

- there is documentation regarding the parent(s)/guardian(s) participation or unwillingness to participate in treatment; and it is documented that the client will not be prescribed psychotropic medications without parental/guardian consent.

MINIMUM CONTENT REQUIRED

- Emancipated: a copy of the minor's Department of Motor Vehicles emancipated minor ID card;
- Self-sufficient: no official designated document; the network provider must consider and document evidence presented by the minor;
- Military: a copy of the minor's military ID;
- Married: a copy of the marriage certificate; or
- In need of mental health services: the network provider must note and attest to the requirements in the Consent of Minor section of the *Consent of Services* form.

Documentation validating at least one of the five special circumstances above must be obtained at the same time the *Consent for Services* form is signed.

Documentation is required only once for minors who are emancipated or are, or have been, married.

Documentation for minors who are in the military, declare themselves to be self-sufficient, or are between the ages of 12–18 must be obtained each time a Medi-Cal beneficiary re-enters service following a discharge by the clinician. A new *Consent for Services* form must also be signed for the new course of treatment.

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION

DEFINED

This process documents the voluntary consent of the Medi-Cal beneficiary to take psychotropic medication after the physician has reviewed all the information with the client listed below under Minimum Requirements:

- *Medication Consent* form *MH 730* (Attachment III)
  https://file.lacounty.gov/SDSInter/dmh/1135992_MH730MedicationConsent.pdf
- *Medication Outpatient Review* form MH 556 (Attachment IV) is required for the following:
  https://file.lacounty.gov/SDSInter/dmh/1006199_MH-556-Outpatien-Med-Review-9-26-16.pdf
  - When a new or different type of medication, such as anti-depressant or anti-psychotic, is prescribed;
  - At least annually, even if there is no medication change; and
  - When the client resumes taking medication following a documented withdrawal of consent.

MINIMUM CONTENT REQUIRED

- Explanation of the nature of mental disorder, what the medication(s) will address and why psychotropic medication is being recommended;
- The general type of medication being prescribed (anti-psychotic, anti-depressant, etc.) and the medication's specific name;
- The dose, frequency, and administration route of the medication(s) being prescribed;
- Situations, if any, which may warrant taking additional medications;

- How long it is expected that the client will be taking the medications;
- Potential side effects; and
- Whether there are reasonable treatment alternatives.
- Signed by the beneficiary
- A statement that informs the beneficiary that the consent may be withdrawn at any time by the beneficiary

AUTHORIZATION STANDARDS

This section, which is in compliance with the LMHP interpretation of Health Insurance Portability and Accountability Act (HIPAA) regulations, is not to be viewed as legal advice or take the place of advice provided by your legal counsel.

The LMHP authorization forms at the end of this section may be adopted by network providers or used as a reference in developing your own unique forms. If a unique form is developed, it is important to ensure that all the required information is included.

Form deficiencies identified during reviews are frequently the result of the absence of required information. To provide assistance with developing unique forms, the minimum content for the Access and Authorization forms are included in this section.

The following types of authorizations are required:

- Medi-Cal beneficiary's access to his/her health information
- Medi-Cal beneficiary's authorization to release or request information

CLIENT ACCESS TO PROTECTED HEALTH INFORMATION

A client has the right to inspect and obtain a copy of their protected health information (PHI) in a designated record. Upon submitting a request to the network provider, any current or former adult client, any minor client authorized by law to consent to treatment and any client's legally authorized personal representative, has the right to inspect and receive copies of the PHI contained in the mental health record. A client's request for access to health information is processed with the *Authorization for Use or Disclosure of Protected Health Information* form *MH602* (Attachment V)
https://file.lacounty.gov/SDSInter/dmh/1164702_MH602AuthorizationforUseorDisclosureofProtectedHealthInformation_English-Fillable.pdf

After receipt of a Notice of Adverse Benefit Determination (NOABD), the beneficiary has a right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

There are a limited number of circumstances in which a client may not have access to all or some of his/her PHI, such as information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

DEFINITIONS

- Access: to inspect, copy or arrange for copying, PHI maintained by the LMHP or its business associates.
- PHI: under HIPAA, any information about health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted to include any part of a client's clinical record or payment history.

MINIMUM CONTENT REQUIRED

- Client name;
- Indicate if the request is to access and inspect health information or to request a copy of health information;
- Description of the information to be accessed, copied or inspected;
- Inspection period;
- Fee information;
- Statement of rights:
- To receive a copy of the signed request;
- To request a review of denial of access;
- Signature of the client or the client's personal representative; and
- Verification of identity.

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

It is the network provider's responsibility to obtain a client's written authorization before using, requesting, or disclosing PHI for purposes other than treatment, payment or mental health care, except as permitted by the HIPAA Privacy Rule. Use and disclosure of a client's PHI must be consistent with the valid authorization obtained from the client.

A network provider may release PHI under HIPAA rules only with a valid *Authorization for Use or Disclosure of Protected Health Information* form unless the rules specifically allow release without an authorization. The authorization is to be documented in a standard form. The authorization form is to include required elements, which will be more extensive if the network provider, rather than the client, is requesting release of the information.

DEFINITIONS

- Disclosure: to release, obtain, transfer, provide access to, or divulge in any other manner, PHI outside the entity holding the information.
- Use: the sharing, application, utilization, examination, or analysis of such PHI within an entity that maintains such information.

MINIMUM CONTENT REQUIRED

- Client name;
- Name of disclosing party;
- Name of recipient of PHI;
- Information to be released;

- Purpose of disclosure;
- Expiration date;
- Statement of right to receive a copy of, and right to revoke the authorization;
- Statement that refusal to sign the authorization form will not affect the client's ability to obtain treatment; and
- Client signature and date.

In addition, an *Authorization for Use or Disclosure of Protected Health Information* form must contain further elements if the network provider is requesting the information for his/her own purposes, e.g., if a network provider is seeking authorization to use/disclose PHI that is already in his/her custody or if the network provider will be receiving any remuneration as a result of use or disclosure.