GILEAD
COMMUNITY SERVICES, INC. • Serving Middlesex County
Improving Lives, Building Futures

CONSENT TO TREATMENT AND TO USE/DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND OPERATIONS

Subject to the statements printed on page two, I, _____(Print Name), the undersigned client, agree to participate in Gilead Community Services, Inc.'s programs and give my consent for Gilead to provide me evaluation, treatment, and other services that may be mutually agreed upon. I also hereby authorize Gilead Community Services, Inc. to use my medical information, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related, and psychiatric information ("Protected Health Information" or "PHI") for treatment, payment, and health care operations purposes.

In addition, I authorize Gilead Community Services, Inc. to disclose my Protected Health Information (which may include, but is not limited to, my name, address, date of birth, dates of service, and medical information, including psychiatric, drug/alcohol abuse, and confidential HIV-related information) to the following:

- Authorized Gilead personnel both within and outside of my program/s for the purposes of enhancing my treatment and/or ensuring the quality of my care.
- My health insurance provider/s (i.e. Medicaid, Medicare, Blue Cross & Blue Shield, etc.) or other payor/s I notify Gilead of, as necessary, for the purposes of processing health insurance claims & payment for provided services.
- Pharmacies, laboratories, or other third parties who perform functions essential to my healthcare, to best coordinate my care.
- The State of Connecticut's Department of Mental Health & Addiction Services (DMHAS) and its designees for the purposes of payment, treatment coordination, and quality assurance (*Only if I am receiving Gilead services that are funded by DMHAS*).
- The State of Connecticut's Department of Children & Families (DCF) and its designees for the purposes of payment, treatment coordination, and quality assurance (*Only if I am receiving Gilead services that are funded by DCF*).
- Other and for what purpose: _____

Gilead Community Services, Inc.'s Notice of Privacy Practices further explains how Gilead may use and disclose my Protected Health Information. I understand that I have the right to review such notice before signing this consent. I also understand that Gilead Community Services, Inc. reserves the right to change its privacy practices described in its Notice, and that if I wish to receive notification of any changes to the notice, I may contact Gilead's Client Rights & Privacy Officer. Updated Notices are also posted at each Gilead program or on Gilead's website at www.GileadCS.org.

I understand that I have the right to request that Gilead Community Services, Inc. restrict how protected health information about me is used or disclosed for treatment, payment, or health care operations, and that Gilead Community Services, Inc. is not required to agree to this restriction. If Gilead Community Services, Inc. does agree to a restriction I request, Gilead Community Services, Inc. will be bound by our agreement.

This consent will be valid for a period of one year from the date below or one year after discharge, whichever is later. I understand that I have the right to revoke this consent by notifying Gilead's Client Rights & Privacy Officer in writing, except where Gilead Community Services, Inc. has already taken action in reliance on this consent. However, I also understand that Gilead Community Services, Inc. may condition treatment on my granting of this consent and that if I revoke my consent, I may be discharged.

I have had the opportunity to have all my questions answered regarding Gilead Community Services, Inc.'s Privacy Practices.

Client Signature: _____ Date: _____

Conservator/Guardian Signature: _____ Date: _____
(If Applicable)

Any information released by Gilead Community Services, Inc. to authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

GILEAD COMMUNITY SERVICES, INC.
Improving Lives, Building Futures

Middletown Outpatient Clinic Intake

Identifying Information:

Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number_____

Address: _____

Email Address: _____

Emergency Contact: (Name and Number): _____

Preference for appointment reminders: ☐ email ☐ home phone ☐ cell phone

Demographics:

Race: ☐ American Indian/Native American ☐Asian ☐Black/African American ☐Other ☐White/Caucasian

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Decline to answer; if yes, please specify. _____

Do you smoke or use tobacco products? ☐ Yes ☐ No

Are you currently or have you been in the Military? ☐Yes ☐ No If yes, please list dates and branch of service. _____

Family and personal history:

☐ Married ☐Divorced ☐ Widowed ☐ Separated ☐Single

Do you have any children? _____

How many brothers/sisters do you have? _____

Is there a history of emotional or psychiatric illness in your family? ☐ Yes ☐ No If yes, briefly comment

Employment and Education:

Are you currently employed? ☐Yes ■ No Employer: _____

Education: ☐ High School Graduate (or highest grade attended _____) ☐ Some College ☐ College Graduate ☐ Graduate Degree

Social Support and Leisure
Over past year, describe social relationships, friendships, support networks, leisure activities:

Do you identify with any organized religion, spiritual practice or belief? ☐ Yes ☐ No If yes, describe.

_ Clinical Information

What services are you seeking?

☐Individual Therapy, ☐Group Therapy, ☐Marital or Couples Therapy ☐Medication Management

(Please describe your current symptoms or stress related problems such as relationships, work, health, legal or financial problems.)

What are your treatment goals?

What are some of your strengths?

Treatment History

Have you ever been treated for emotional or psychiatric issues before? ☐ Yes ☐No

If yes, please list date (approximate) and where you were treated:

Have you ever been treated for alcohol or substance use issues? ☐ Yes ■ No

If yes, please list date (approximate) and where you were treated:

Are you currently being prescribed medication for emotional or psychiatric problems? ☐ Yes ☐ No
If yes, complete the following:

Name of Medication(s):_____

Name of Phone Number of MD/APRN:
_____

How long have you taken these medications? _____

Do you have a primary care physician? ☐ Yes☐ No If yes:

Name and phone number of MD/APRN

Are you being treated for any medical problems? ☐ Yes ☐ No If yes please describe:

Are you allergic to any medications? ☐Yes ☐ No If yes, please list:

Gilead Community Services, Inc.'s
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

How Medical Information about You ("Protected Health Information" or "PHI") May be Used and Disclosed by Gilead Community Services, Inc.:

- Gilead Community Services, Inc. receives and generates certain Protected Health Information about You that is stored in a medical record especially for You.
- Federal and State law requires that we maintain the privacy of Your Protected Health Information;
- Federal law requires that Gilead Community Services, Inc. provide You with this written Notice regarding its duties and practices in using Your Protected Health Information;
- Gilead Community Services, Inc. is required to abide by the terms of this Notice;
- Gilead Community Services, Inc. is required to notify You if it can't abide by a requested restriction on how your information is used or disclosed;
- Gilead Community Services, Inc. must accommodate reasonable requests that You make for it to communicate Your Protected Health Information by alternative means or locations; and
- Gilead Community Services, Inc. reserves the right to change this Notice and have the changes apply not only to Protected Health Information acquired after the change in Notice, but have it also apply to Protected Health Information received before the change in Notice. Should our Notice be revised, we will post the revised Notice in each Gilead Program and on our Web site (www.GileadCS.org).

Gilead Community Services, Inc. may use Your Protected Health Information for the following purposes without obtaining Your written consent:

- To provide ***treatment*** (e.g., discussions between caregivers for coordination and planning of Your care). Treatment means the provision of health care and related services, including coordinating and managing Your health care with a third party, consulting between health care providers; and referring You to another health care provider to receive care; and
- To conduct our administrative and business ***operations***. Health Care Operations, includes, but is not limited to, conducting quality improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, contacting of health care providers and patients with information regarding treatment alternatives, conducting or arranging for legal counsel, medical review and auditing functions, including fraud and abuse detection, business planning and development, management activities relating to compliance with State and Federal laws, resolution of internal grievances, and activities in connection with a sale of assets.

However, State law continues to require that Gilead Community Services, Inc. obtain Your consent for disclosure of Protected Health Information for the following purposes:

- For ***payment*** (e.g., Your insurer/payor will require certain information to support our claim for payment),
- Coordination of care with other providers (e.g. discharge planning and referrals), and
- The disclosure of certain sensitive information protected under State law.

THEREFORE, WE WILL REQUEST YOUR CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION UPON ADMISSION.

Unless the Protected Health Information is protected by Federal and/or State drug, alcohol, psychiatric, or HIV-related information confidentiality laws, we may use and disclose Your Protected Health Information without Your consent as follows:

- If the use or disclosure of Protected Health Information is required by law and is limited to the relevant requirements of the law (e.g., reporting an adverse incident in our agency,);
- Disclosures made by law to state and federal public health authorities (e.g., to report a defective medical device to the FDA);
- Disclosures made to government authorities for the purpose of reporting suspected abuse and neglect of children, the elderly, and the mentally retarded;
- Disclosures to health oversight agencies authorized by law, in connection with audits, civil, administrative, or criminal investigations, licensure or disciplinary actions; or for monitoring compliance and quality, and program eligibility (e.g., Medicare, Medicaid, and State of Connecticut Department of Public Health);
- Disclosures to persons exposed to a communicable diseases if authorized by law to make such disclosure;
- Disclosures in connection with judicial and administrative proceedings in response to an order of the court or administrative tribunal, or in response to lawfully issued subpoena;
- Disclosures to law enforcement if mandated by law (e.g., reporting gunshot wounds);
- Disclosures to law enforcement in the event of Your death if it is suspected that Your death was the result of criminal conduct;
- Disclosures to law enforcement if there is evidence of criminal conduct that occurred on Gilead Community Services, Inc.'s premises;
- Disclosures to the Office of State Medical Examiner as mandated by law (e.g., the occurrence of a suspicious death, contagious disease, and cremation);
- Disclosures to funeral directors as permitted by law;
- Disclosures to notify a family member, legal representative, or other person responsible for you of your death;
- Limited disclosures made in connection with record reviews in preparation for conducting research;
- Disclosures to persons reasonably able to prevent or lessen serious and imminent threat to the health and safety of a person or the public; or if necessary to apprehend an individual involved in a violent crime that we believe may have caused serious physical harm to You;
- Disclosures regarding armed forces personnel to appropriate military command authorities to assure proper execution of the military mission;
- Disclosures to Federal officials for protective services to the President or other governmental authorities;
- Disclosures to correctional institutions for the purpose of providing services to You or for the health and safety of the inmates or employees of the correctional institution;
- Disclosures to comply with workers' compensation or other programs that provide benefits for work-related injuries without regard to fault; and
- Disclosures that are otherwise permitted or required by law.

Permissible Marketing and Fundraising Disclosures: Gilead Community Services, Inc. may make disclosures of Your Protected Health Information to provide follow up contact to you regarding upcoming appointments, treatment alternatives, health-related benefits, programs, services, events and functions which may be of interest to you. Gilead may also contact you for certain fundraising activities.

All other uses or disclosures will only be made with Your specific written authorization, which may be revoked, except to the extent it has already been relied upon.

Special rules for Psychiatric, Drug and Alcohol, and HIV-related protected information:

Protected Psychiatric Information: State law provides special protections when it comes to psychiatric information (e.g., communications between a psychiatrist, psychologist, licensed professional counselor, and licensed social worker, and those working under their supervision, and his or her client). Except for treatment, or Gilead business and administrative operations, psychiatric communications will not be disclosed, without Your specific written consent, unless the disclosure is made: (i) to another health care Provider for the purpose of treatment and diagnosis (with notice to You); (ii) when there is substantial risk of imminent physical injury to You or others and the disclosure is necessary to place You in a treatment facility; (iii) to a court as part of a court ordered psychiatric examination; (iv) in a civil court proceeding if You introduce Your mental condition as an element of a claim or defense; (v) after Your death, when Your condition is introduced by a party claiming or defending through or as a beneficiary of You and a court finds it to be in the interests of justice to disclose such psychiatric information; (vi) to the Commissioner of the State Department of Public Health or the State Department of Mental Health & Addiction Services in connection with an inspection or investigation; (vii) to the family or legal representative of a homicide committed by You; (viii) to individuals or agencies involved in the collection of fees for psychiatric services; (ix) to researchers who meet strict confidentiality standards; and (x) to the State Department of Mental Health & Addiction Services in connection with Gilead Community Services, Inc. receiving payment for services funded by such agency (with Notice to You).

Protected HIV-Related Information: Special rules under State law also limit the disclosure of HIV-related information. According to the rules, Gilead may not disclose such information without Your specific written authorization, unless such disclosure is: (i) made to a public health official as required or allowed by State or Federal law; (ii) a health care Provider for the purpose of treatment; (iii) a medical examiner to determine the cause of death; (iv) to a Gilead Community Services, Inc. Committee or another organization for the purpose of oversight or monitoring of Gilead Community Services, Inc.; (v) to a health care worker experiencing a significant occupational exposure to HIV infection; (vi) pursuant to a court order; (vii) life and health insurers; (viii) to Your partner by a physician caring for You and Your partner if it is believed by the physician that Your partner is at significant risk for transmission; and (ix) if You are a minor, to Your parents or legal guardian, unless the physician determines there is cause (as defined by law) not to disclose to them.

Protected Drug and Alcohol Information: Federal law establishes certain protections for any patient identifiable information relating to drug and alcohol treatment, treatment referral, research and/or rehabilitation, (but excludes protection for a diagnosis of drug overdose or alcohol intoxication or a diagnosis made solely for the purpose of providing evidence for use by law enforcement authorities). As a general rule, protected drug and alcohol information is confidential and may not be disclosed without your authorization or pursuant to Federal law. Exceptions for disclosure of Protected drug and alcohol information without Your authorization are as follows: (i) to medical personnel to the extent necessary to meet a bona fide medical emergency; (ii) to qualified personnel for the purpose of conducting research, management audits, program evaluation, provided You are not identified in any report; (iii) pursuant to a court order where good cause for such disclosure has been established; (iv) communications between a program and an entity and an affiliated covered entity having direct administrative control over our program; (v) to a business associate performing services on Gilead Community Services, Inc.'s behalf; (vi) limited communications with law enforcement regarding a crime committed or threatened by You on our premises; (vii) the reporting of incidents of suspected child abuse and neglect to the appropriate state authorities; (viii) to the FDA when they assert that Your health may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction; and (ix) communications for the reporting of vital statistics, to authorized agencies investigating an individual's cause of death, and to prevent multiple enrollments in certain programs as permitted or required by law.

Your Rights Relating to Your Protected Health Information:

- You have the right to request certain restrictions on the use of Your Protected Health Information for treatment, payment and our operations. However, we are not required to honor such restrictions.
- The right to receive communications of Protected Health Information from Gilead Community Services, Inc. by other means or locations;
- The right to inspect and copy Protected Health Information (the request must be in writing), information collected for use in a court proceeding, or certain other information protected by Federal law governing clinical laboratories;
- The right to request to amend Protected Health Information so long as the amendment is accurate and complete:
- The right to revoke your Authorization and Consent except to the extent relied upon by notifying, in writing, the Gilead Community Services, Inc.'s Program Director for the Program in which you are receiving services.
- You have the right to request an accounting of disclosures for a period of six years prior to the date of the request within 60-90 days of your request (but not including disclosures that occurred prior to April 14, 2003).
- You have the right to request a paper copy of this Notice of Privacy Practices.

Information and Complaints: For more information on how to exercise any of your rights regarding Your protected health information, or if you feel your privacy or any other rights have been violated, you may file a complaint with Gilead Community Services, Inc.'s Client Rights & Privacy Officer at 222 Main St. Extension, Middletown, CT 06457 or call (860) 343-5300. Or, for privacy rights only, you may choose to complain directly to the U.S. Secretary of the Department of Health and Human Services. Please contact Gilead's Client Rights & Privacy Officer to obtain the correct address for the Secretary. ***You will not be retaliated against for bringing a complaint.***

Gilead Community Services, Inc.
Notice of Privacy Rights Acknowledgement

I, _____ (Print Name), hereby acknowledge that:

- I have been provided a copy of Gilead Community Services, Inc.'s Notice of Privacy Practices (and the Pamphlet entitled "*Client Privacy: Your Rights and our Responsibilities Under the Law*") prior to consenting to the use and disclosure of my Protected Health Information for treatment, payment, and operations;
- I have had the opportunity to ask any questions regarding my rights relating to the use and disclosure of my Protected Health Information;
- I have been told that I may request restrictions on the use and disclosure of my Protected Health Information;
- I understand that I may request communications at alternate locations and by alternative means;
- I have been told that I have the right (in most instances) to review or copy information in my medical record;
- I understand that I may request an amendment to my protected health information;
- I have also been told that I have the right to an accounting of the disclosures of my protected health information that were not for treatment, payment, or operations purposes (or other disclosures exempted by law); and
- I furthermore understand that I have the right to complain if I feel my privacy rights have been violated.

Client Signature: _____ Date: _____
(Only Clients aged 14 or older should sign)

Conservator/Guardian Signature: _____ Date: _____
(If Applicable)

THE FOLLOWING IS FOR STAFF USE ONLY

** Gilead Staff should complete the following only if applicable.*

As a Gilead staff member, I, _____ (Print STAFF Name), attempted to obtain from the Client named at the top of this form their written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason/s:

☐ Client refused to sign.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ Other (Please Specify): _____

Gilead staff will reattempt obtaining this acknowledgement when/if the above reasons no longer apply.

Staff Signature: _____ Date: _____

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Gilead Community Services Inc. Gilead - Client Rights and Grievance Form

Requirement Information

Document: Client Rights and Grievance Acknowledgement

Effective Date:

Expiration Date (1 year after the effective date):

Client Rights

Individuals receiving services from Gilead Community Services are entitled to the following rights:

Equal Humane and Dignified Treatment:: You have the right to receive equal treatment regardless of race, creed, national origin, language, gender, sexual orientation, marital status, or physical disability. You have the right to be treated in a humane and dignified way at all times, and with full respect to your personal dignity, right to privacy, right to personal property & civil rights. You have the right to freedom from physical or mental abuse, neglect, exploitation, harm, humiliation, and retaliation.

Treatment Planning:: You have the right to a written treatment plan which is developed with your input & participation. You have the right to a copy of this written treatment plan. You also may request a review of the treatment plan at any time to answer concerns regarding its adequacy or effectiveness.

Privacy Confidentiality Informed Consent:: You have the right to privacy & confidentiality. You have the right to expect that discussions involving your care will not occur within hearing of others not involved in your care. Any information or written records that would identify you, your diagnosis, or manner of treatment cannot be disclosed outside of Gilead Community Services, Inc. without your informed written consent, except where explicitly allowed by law. If you decide to participate in research at Gilead, Gilead Community Services, Inc. will adhere to research guidelines and ethics.

Visiting and Communication Rights:: You have the right to visit with & have private conversations with clergy, attorneys or paralegals of your choice at any reasonable hour. You may send & receive mail, telephone calls, or other communications and these cannot be intercepted, read, or censored. If you reside in a group home, you may receive visitors at any reasonable hour within designated areas. Any exceptions to rights regarding communications must be explained in writing, signed by the Chief Executive Officer, and made part of your clinical record.

Access to your Medical Record:: You or your legal conservator/guardian have the right, upon written request & following designated protocol, to inspect your treatment records. You have the right to access information pertinent to you in sufficient time to facilitate your decision making. Gilead Community Services, Inc. may refuse to disclose any portion of your records which Gilead Community Services, Inc. has determined would create a substantial risk that you would inflict a life threatening injury to yourself or others, experience a severe deterioration in mental state, or would constitute an invasion of privacy of another.

Denial of Employment Housing etc:: You cannot be denied employment, housing, civil service rank, any license or permit, or any other civil or legal right, solely because of a present or past history of a mental

disorder, unless otherwise permitted by federal/state statute.

Changes Additions or Refusals of Tx or Services:: You have the right to ask for changes in or additions to your treatment, services, assigned staff, programs (including concurrent services), or medication. You also have the right to refuse treatment, services, assigned staff, programs (including concurrent services), medication or involvement in research projects, if applicable.

Filing of Grievances:: You have the right to file a grievance if the staff or agency has (1) violated a right provided by statute, regulation, or policy, (2) treated you in an arbitrary or unreasonable manner, (3) denied you services authorized by a treatment plan due to negligence, discrimination, or other improper reasons, (4) engaged in coercion to improperly limit your treatment choices, (5) unreasonably failed to intervene when your rights have been jeopardized in a setting controlled by this agency, or (6) failed to treat you in a humane or dignified manner.

Access to Supports:: You have the right of access or referral to legal representation, self-help and advocacy support services.

Other Rights:: You may also be entitled to additional rights (granted by either federal/state statute, regulations, or policies) not identified in this list. You are encouraged to seek counsel to learn about or better understand these laws & policies.

Client Responsibilities

Individuals receiving services from Gilead Community Services have the following responsibilities:

Providing Information and Reporting Changes:: You are responsible for providing, to the best of your knowledge, accurate and complete information about problems, past treatment, medications, and other issues pertinent to your physical & mental health. You are also responsible for reporting any changes in your condition to staff responsible for your care.

Following your Treatment Plan:: You are responsible for following the treatment plan that you participated in developing (as outlined above).

Work Together Towards Treatment Goals:: You and staff will work together to achieve treatment goals.

Keeping Scheduled Appointments:: You are responsible for making every effort to keep scheduled appointments.

Following Rules:: You are responsible for following the rules and directions provided by staff with regard to safe and respectful behavior within the facility. Verbal or physical intimidation or force is prohibited. Alcohol, non-prescribed drugs, and weapons are also prohibited on the premises of the agency.

Respect the Rights of Others:: You are expected to respect the rights of other clients, families, and all agency staff.

Client Grievance Procedure Summary

The following grievance procedure is available to all Clients of Gilead Community Services:

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Gilead Community Services Inc. Gilead - Client Rights and Grievance Form

Grievance Overview:: Gilead Community Services, Inc. and its staff strive to uphold the rights of all its clients at all times while providing the best possible clinical treatment. However, if at any time you have a concern regarding your care or feel that your rights have been violated, you are encouraged to use the following procedure in an attempt to resolve your concerns as quickly and effectively as possible. No client shall be subject to retaliation or barriers to services as a result of filing a grievance.

[1]: You should first raise your concern directly with the staff person with whom you have the problem in an effort to work together to resolve it.

[2]: If you are unsatisfied with the results of this attempt, you may complete a Grievance Form (available from the Client Rights & Privacy Officer or any staff person) and submit it to the Client Rights & Privacy Officer.

[3]: If your issue is regarding a violation of your privacy rights, you may choose to file a grievance directly to the Client Rights & Privacy Officer and/or to the Secretary of the Department of Health and Human Services at the Patient Relations Office.

[4]: You, your conservator of person, or a person designated by you (such as an advocate, family member, significant other, or friend) may file a formal grievance with the Client Rights & Privacy Officer if the agency or its staff has [1] violated your rights provided by statute, regulation, or policy; [2] treated you in an arbitrary or unreasonable manner; [3] denied you services authorized by a treatment plan due to negligence, discrimination, or other improper reasons; [4] engaged in coercion to improperly limit your treatment choices; [5] unreasonably failed to intervene when your rights had been jeopardized in a setting controlled by this agency; or [6] failed to treat you in a humane or dignified manner.

[5]: At your request, the Client Rights & Privacy Officer or agency staff can assist you in obtaining a Grievance Form, completing the form, or filing the grievance.

[6]: A Grievance must be filed within 45 days of the action complained of, unless a good reason can be shown for late filing.

[7]: A grievance may be withdrawn at any time.

[8]: Once received, the Client Rights & Privacy Officer will investigate your grievance and attempt to work out any resolutions, if possible. The Client Rights & Privacy Officer may offer a written informal resolution proposal (which you will have 10 business days to consider) and/or the Chief Operating Officer (COO) will make a Final Decision all within 21 days of receipt of the grievance (not counting any time during which you are considering an informal resolution proposal), unless the COO has authorized an additional 15 days for reasonable cause.

[9]: For DMHAS funded programs only, if you are still unsatisfied with this Final Decision, you may file an appeal in writing with a designee of the Commissioner of DMHAS within 15 days of receipt of the Final Decision.

Electronic Signatures

Acknowledgement:: I acknowledge that I understand and have read and/or discussed the Client Rights, Responsibilities, and Grievance Procedure with staff. I was also given an opportunity to ask questions and was offered a copy of the associated policy & procedures for future reference.

Client Signature

Client Signature:

Client Signature Date:

Conservator/Guardian Signature (if applicable)

Conservator/Guardian Signature (if applicable):

Conservator/Guardian Signature Date:

Manual Signatures (if needed)

Scanned Signed Form (if needed):

Staff Responsible

Staff Responsible:

Tasks/Schedules

Next Event Due:

GILEAD
COMMUNITY SERVICES, INC.

P.O. Box 1000, 222 Main St. Extension, Middletown, CT 06457 • (860) 343-5300 • Fax (860) 343-5306

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ Date of Birth: _____
Address: _____

Subject to the statements printed on page two, I, the client named above, hereby authorize Gilead Community Services, Inc. to use my medical information, including, if applicable, protected drug &/or alcohol abuse, confidential HIV-related, & psychiatric information ("Protected Health Information") for the purposes described below, & to obtain Protected Health Information from or release Protected Health Information to the following:

Name/Agency: _____ Phone *(if known)*: _____
Address: _____
_____ Email *(optional)*: _____

The nature and extent of Protected Health Information to be used or disclosed
[Check Yes or No to indicate which of the following types of information may be used or disclosed. Each line item must have a Yes or a No checked.]:

Yes	No		Yes	No	
☐	☐	Discharge Summary / Information	☐	☐	Educational Information
☐	☐	Psychosocial Assessments / Information	☐	☐	Vocational Information
☐	☐	Psychiatric Summary / Information	☐	☐	Financial Information
☐	☐	Substance Abuse Summary / Information	☐	☐	Housing Information
☐	☐	Confidential HIV-related Information	☐	☐	Other: _____
☐	☐	Medical Information/Physical Exam	☐	☐	Limitations on Disclosure (if any):
☐	☐	Legal Information			_____

This authorization and any information released under it are to be used for the following purpose(s)
[Check all that apply, but at least one purpose must be checked.]:

☐ To provide ongoing treatment/rehabilitative/recovery services
☐ To coordinate service efforts with family/concerned persons/treatment providers
☐ Other: _____

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of two years from the date below. I understand that this information may be used/disclosed on an ongoing basis and that it may include written, oral, or electronic information communicated by mail, phone, fax, email, or in-person communications. I understand that I may revoke this authorization at any time by notifying my Gilead Primary Plan Manager (who will document the revocation on this form), but if I do, it won't have any effect on actions Gilead Community Services, Inc. took before it received the revocation. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or continued treatment by Gilead Community Services, Inc. is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Client Signature: _____ Date: _____
(If Client has a guardian/conservator of person, client signature indicates only that this authorization has been reviewed)

Conservator/Guardian Signature: _____ Date: _____
(If Applicable)

Primary Plan Manager to complete this area ONLY in the event this Authorization is revoked:
Date this Authorization was revoked: _____ Attested to by (signature): _____

Any information obtained or released by Gilead Community Services, Inc. to authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.