Authorization for Release of Information

Client Name: _________________________________ **Client DOB:**________________

A. To other Agency or Individual Please check here ☒
I hereby grant permission for the agency or individual named below to discuss or send the information checked below regarding information needed for me or my child evaluation, treatment and/or need information to participate in program services by LAMOUR. ***I authorize to receive and release information from either verbally or in writing, as indicated in this authorization.***

B. To LAMOUR Please check here ☐
I hereby grant permission for the LAMOUR to discuss or send the information checked below regarding my child's evaluation and/or treatment to DCF, DMH, DYS, and or the agency named below as collaboration in treatment below.

- ☐ School Counselors, Administration, Teacher and staff
- ☐ Attendance records
- ☐ Individual Education Plans
- ☐ Admission Note
- ☐ Treatment Plans
- ☐ Discharge/ Termination
- ☐ History & Physical Exam
- ☐ Psychiatric Assessment
- ☐ Medical Insurance Services
- ☐ Attorneys & Legal Advocates
- ☐ Psychology Testing
- ☐ Education Testing
- ☐ Any information relevant Psychotherapy
- ☐ Other (specify): __________________________
- ☐ Coordinate or Setup Medical, Dental, or any other appointment related to treatment goals

☐ I further authorize release of any information

Name of School/Agency/Clinic/Hospital:
____

Name of Specific staff:____

Phone Number: __________________________________ Ext:________________________

Address: _______________________________ Town:______________ Area code:________

Print and Sign your Name below (at least one signature required below)

Parent/Guardian/Adult in Custody Signature:

Signature: ____ **Date:** ____________

Printed Name: ____

****Must be signed by parent or adult in custody if client is under 18****

Client Signature*: ____**Date:**___________

Printed Name: ____

Acknowledgement of Receipt

And

Consent to treatment/ Participate in Programming

Client Name: ____________________Client DOB: _______

1. **Acknowledgement of Receipt of notice of privacy practices**
2. **Acknowledgement of Receipt of complaint information**
3. **Acknowledgement of Receipt of patients rights**
4. **Acknowledgement of Receipt of off hours emergency policy**

It is the policy of the LAMOUR to provide all patients, or their parents, guardians, or personal representatives, a copy of our current notice of privacy practices prior. This signed acknowledgement is to be filed in the medical record.

I have received the notice of privacy practices, the complaint information, the patient's rights sheet, and the off hours emergency policy.

5. **Acknowledgement of Consent to treatment**

I consent to be evaluation, treatment and/or to participate in program services by LAMOUR.

Parent/Guardian/Adult in Custody Signature:

Signature: ____ **Date:** ______________________________

Print Name: _____________________**Relationship to patient:** ___________________________

Must be signed by parent or adult in custody if client is under 18

Printed Name: ____

Client Signature: ____**Date:** __________________

Staff use only:

Complaint Filing Policy and Procedure

Policy

LAMOUR acknowledges that clients and staff have a right to raise concerns and have them addressed by the appropriate member of staff. Complaints should be handled objectively and with sensitivity, and not in a reactive and subjective manner. Clients can call Patrice Lamour, The Clinical Director at (781)885 - 7252. The most desirable outcome in cases of complaints against clinicians and fee for services independent contractors members of staff is:

We shall provide clients access to a complaint process that promotes resolution of such complaints at the lowest level possible, protects client rights, and promotes quality improvement in the delivery of publicly funded community mental health services.

Procedure

Investigation oversight

The office quality control coordinator or an appropriate senior administrative staff member will be responsible for the overseeing of a serious complaint investigation.

Reporting procedure

In case of a client presenting a serious complaint against an employee or staff member of LBD, A filled out complaint form from said client will be given to the designated administrator within one day from the clinic staff, in writing, reporting said serious complaint(s).

Investigation Process

Where, in the professional judgment of the office manager or appropriate senior administrative staff member who has received the complaint, there is a need for a complaint to be addressed, the clinician, fee for services independent contractor or staff member concerned must be informed and involved.

The client who has made the complaint should be requested by the administrator who receives the complaint, to discuss the concern with the clinician or staff member concerned. This process shall be documented and maintained.

Upon primary interview with the client, a complaint file shall be put together that shall include the following: the original complaint form, the progress reports as investigation is carried out and outcome of investigation including action taken, if any. Where the complaint I found to be vexatious or based on misinformation etc, any record pertaining to the complaint or handling of the complaint must be given to the clinician, fee for services independent contractor or staff member concerned.

File Availability

The complaint file record will be made available for inspection by agents of the Department of public Health

Off Hour Emergency Policy

In the event of a client emergency after, the clinical team serving you can be contacted 24 hours. Clients can also call Patrice Lamour, The Clinical Director at (781) 885-7252 press 0 or contact clinician below directly. If your clinician or the services provider working with you has made specific arrangements with you about after-hours emergency contact, please adhere to his/her instructions or by contacting them. The information located below.

Service provider name:_______________________Phone: ____________________

Service provider name:_______________________Phone: ____________________

On call number: (781) 885-7252 press 0