

**Naval Medical Center Portsmouth, Directorate of Mental Health
Limits to Privacy and Confidentiality and Informed Consent to Participate in Treatment**

It is important for you to know the limits to privacy and confidentiality regarding your appointments within the Directorate of Mental Health (DMH) at Naval Medical Center, Portsmouth. This notice is written in accordance with departmental policy, military guidelines, and regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the final Privacy Rule of 2000. Clinics within DMH are committed to compliance with HIPAA privacy regulations.

When you speak with a mental health provider, the notes and results of your initial evaluation and subsequent visits are entered into your electronic medical record (AHLTA) as maintained by the Department of Defense under your or your sponsor's social security number and will be designated as "sensitive", which offers the highest level of privacy available for this information. Access to portions of your electronic record by third parties is only allowed when required by law, regulations, or judicial proceedings. This is consistent with the Privacy Act Statement (DD Form 2005) maintained in your hard record and the HIPAA Notice of Privacy Practice.

As a rule, your mental health provider will disclose no information obtained from your contacts with them, or the fact that you are receiving care in this clinic, except with your written consent. However, there are some important exceptions to this confidentiality rule as described by the following or as otherwise specified by law.

- As general practice, we will use and disclose your protected health information to provide, coordinate, or manage your health care and related services as described in the HIPAA Notice of Privacy Practices.
- Contents of your record may also be reviewed by other health care providers for supervision, consultation and quality assurance.
- If you reveal information about child abuse or neglect, or physical abuse of elders or dependent adults, we are required to report it to civil authorities.
- If you report spousal/partner abuse or drug abuse, we are required to report it to military authorities.
- If you are judged to be suicidal or a threat to yourself, we are required to take what action is necessary to ensure your well being.
- If you are a threat to another person (for physical harm or death), we are required to warn the intended victim and the appropriate law enforcement agencies.
- If a court of law issues a legitimate subpoena, we are required to provide the information specifically described in the subpoena.
- If you report a violation of The Uniform Code of Military Justice (UCMJ) or civil law we may be required to report it to the appropriate authorities.
- If you are Active Duty, your command may be advised of conditions that impact your fitness or suitability for duty or mission readiness. This may include disclosure to the service member's Commanding Officer or an officially appointed or delegated Commanding Officer Representative and relevant Medical Department Personnel. We may disclose protected health information about yourself to your Commanding Officer, or his/her delegate, for proper execution of the military mission purposes and to relevant Medical Department personnel for payment, treatment, or healthcare operations purposes.

STATEMENT OF UNDERSTANDING AND INFORMED CONSENT

I have been advised and understand that all information obtained as herein described will be used in confidence and in conformity with the Health Insurance Portability and Accountability Act (HIPAA) and/or other restrictions and protections required by any applicable law(s).

As a result of a Behavioral Health evaluation, I have been informed of and recommended to participate in a specified appropriate level of treatment based on my preliminary diagnosis. I have also been informed that my treatment may utilize a combination of assessment and treatment modalities to include, but not limited to: individual counseling or therapy, group therapy, pharmacotherapy, psychological testing, biofeedback treatment, and assessment using laboratory and/or radiological testing.

I have been informed that I may refuse any or all aspects of treatment at any time, but that this refusal might result in worsening of my mental health conditions. This consent form will be maintained in my medical record. **I also understand that I may revoke this consent at any time, and that if I do so, by signed/dated revocation, it shall be made part of my medical record.**

Please initial one of the following:

a. I consent to mental health treatment. b. I do not consent to treatment at this time.

Patient/Parent/Guardian Signature	SS#/ID	Date	Time
Staff Signature	Date	Time	

HOSPITAL OR MEDICAL FACILITY Naval Medical Center, Portsmouth	STATUS	DEPART/SERVICE Outpatient Psychiatry	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION <i>(For typed or written entries, give: Name – last, first, middle; ID No or SSN; Sex; Date of birth; Rank/Grade.)</i>		REGISTER NO.	WARD NO.

Name: Department of Psychiatry
 SSN: ___/___-___-___ Naval Medical Center Portsmouth
 DOB: ___/___/___ 620 John Paul Jones Circle, Bldg 215 3rd Floor
 Portsmouth, VA, 23708
 Office: (757) 953-7641

CHRONOLOGICAL RECORD OF MEDICAL CARE
 Medical Record
STANDARD FORM 600 (REV. 6-97)
 Prescribed by GSA/ICMR
 FIRM (41 CFR) 201-9.202-1