the Montrose Center™

FAMILY SUPPORT GROUP

Participants of the Intensive Outpatient Program are encouraged to invite significant people that make up your family of Choice to the Family Support Group. The group meets on the Thursdays from 6:30 – 8:00 PM.

My Choices:
1.

2.

3.

As an IOP participant, I have agreed to the following requirements:

1. Make a weekly appointment for Individual Counseling.
2. Attend at least three support groups each week (one must be recovery focused).
3. Immediately obtain and begin work with a Recovery Sponsor or Coach.
4. Call a staff member with an explanation before any tardiness or absence.

Signature ___________________________________

AREA RESOURCES

MENTAL HEALTH / CRISIS SERVICES
Neuro Psychiatric Crisis Clinic: 713.970.7070
Gay & Lesbian Switchboard Houston: 713.529.3211

HOUSING / SHELTER
SEARCH: 713.739.9201

HEALTH CLINICS
Legacy Community Health Services: 713.366.7444
City of Houston Medical Clinic: 713.794.9660
Good Neighbor Healthcare Center: 713.529.5597

FAMILY SERVICES
Houston Gay & Lesbian Parents: www.hglp.org
Family Service Center: 713.861.4849
H.A.T.C.H. – youth support program for GLBTQ youth: 713.529.3590
Parents & Friends of Lesbians & Gays (P-FLAG): 713.867.9020

SELF HELP / SUPPORT GROUPS
Peer support groups meeting at the Center → http://www.montrosecenter.org/hub/calendar-of-events/
Depression Bipolar Support Alliance www.dbsahouston.org
Lambda Center (Gay & Lesbian AA & Alanon): 713.528.9772
ALANON: 713.683.7227
AA Intergroup: 713.686.6300
ACA: 713.683.7227
Cocaine Anonymous: 713.668.6822
COC-ANON: 713.668.6822
Narcotics Anonymous: 713.661.4200
Nicotine Anonymous: 713.827.5989
AA for Spanish Speaking: 713.468.7481
Codependents Anonymous: 713.521.3180
Sex & Love Addicts Anonymous: 713.781.3999
Gamblers Anonymous: 713.684.6656
Overeaters Anonymous: 713.973.6633
Trans Lifeline: 877.565.8860

ADDITIONAL RESOURCES
The Council on Alcohol & Drug Abuse – Houston: 713.942.4100
Veterans Administration Hospital: 713.791.1414
Gulf Coast Legal Foundation: 713.652.0077
Consumer Credit Counseling: 713.923.2227
Texas Rehabilitation Commission: 713.862.5294
Houston Lesbian & Gay Community Center: 713.862.5294

1.1 STATEMENT OF CLIENT RIGHTS & RESPONSIBILITIES

RIGHTS

All applicants/clients/participants/families (client or through their surrogate) admitted to services and applicants for services of the Montrose Center shall have all the rights and responsibilities of other residents of the State of Texas and the United States of America including the following rights and responsibilities:

1. **Confidentiality:** Clients have the right to confidentiality. No information from which the identity of clients or their treatment can be determined shall be given directly or by reference to the public or any other individual or agency without the written consent of the client as governed by local, State, and Federal regulations.

   The law authorizes the Center to disclose information in the case of: (1) a court order, (2) imminent harm that might come to the client or others (child abuse, homicide, suicide, physical harm, abuse by a previous Therapist), (3) mandatory reporting for abuse or suspected abuse of children, the elderly or people with disabilities; and (4) coded intake, treatment and follow-up data (with client name removed) sent to the funding source as a requirement for sponsorship. In addition, coded data (client name removed) or aggregate data is used by the Center for the purpose of program evaluation and research. Clients have the right to be informed when information is released without permission due to the above listed exceptions.

   By appointment, clients may inspect their own clinical and financial records that are maintained by the Center, unless deemed harmful to the client. Copies can be obtained by signing a release. Copies shall be available within seven (7) calendar days of the request. There is a fee of 10¢ per page unless the copy is necessary to file or appeal a disability claim or designation.

2. **Discrimination:** Clients have the right not to be discriminated against and to receive appropriate care. No person shall be denied services in any the Center program based on their age, sex, race, ethnicity, creed, national origin, sexual/affectional orientation, gender identity or expression, physical or mental ability, religious practice or preference, HIV status, chemical dependency status, marital status, or pregnancy, although, some programs give priority to certain groups or target populations.

   No person who qualifies for grant subsidized services shall be denied services based on their ability to pay for the services.

3. **Research:** Clients have the right to refuse to participate in research without affecting access to services.

4. **Informed Consent:** Clients have the right to give informed consent or to refuse treatment and to be advised of the consequences of such a decision. Informed consent includes information about the condition to be treated; the proposed treatment; risks, side effects, and benefits of all proposed treatments; alternative treatments and which ones might be appropriate; probable physical and mental health consequences if treatment is refused; and expected length of stay. If a client is disoriented or lacks the capacity to under this at the time of admission, they are informed again when they are able to understand.

   Clients have the right to accept, refuse or withdraw from treatment after receiving the above information and to leave treatment at any time, unless otherwise prohibited by law. All services at the Center are outpatient and voluntary.

5. **Treatment/Service/Wellness Plans:** Clients have the right to actively participate in the development of an individualized treatment plan including periodic review at least once a month.

   Clients have the right not to be given medication not needed or too much medication. The Center does not prescribe or administer medications.

   Clients have the right not to be held or placed in a locked room alone unless the client is a danger to themselves or others. The Center does not use personal restraint in treatment.

   Clients have the right to participate in an client annual needs assessment and client satisfaction survey. Surveys are available in the lobby and at the reception desk throughout the year.

   Clients have the right to receive individualized services and to refuse or accept services after being informed of services and responsibilities, including: program goals and objectives, rules and regulations and client rights.

   Clients have the right to include members of the client's family of choice in treatment planning and discharge planning.

6. **Provider Information, Communication and Choice:** Clients have the right to know the identity and qualifications of the staff providing treatment and to have competent, qualified and experienced staff to supervise and carry out services. Clients have the right to know the reason for any proposed change in staff responsible for their care. Clients have the right to an explanation of any professional relationship between the Center and any other health care or educational institution involved in the client's care. Clients have a right to a second opinion.

   Clients have the right to be informed about program rules and regulations before admission.

   Clients have the right to have freedom of choice when choosing a provider of comprehensive outpatient health and psychosocial support services.

   Clients have the right to appropriate treatment in the least restrictive setting available that meets the client's needs. The Center only provides outpatient services. The right to designate a surrogate decision maker if the client is incapable of understanding a proposed course of care or is unable to communicate their wishes regarding that care.

   Clients have the right to free communication within the constraints of the individualized treatment plan with justification for any restrictions documented in the client's record. Since the Center is an outpatient facility, there are no restrictions.

   Answering Service: the Center answers the phones during normal business hours and utilizes an answering service after 7:00 pm weekdays and on weekends for emergencies.

   The Center phones and employees home phones show up as anonymous on Caller ID. If a client does not accept anonymous calls, the Center's number will appear on the Caller ID.

7. **Complaints and Grievances** (see section on complaints)**:** Clients have the right to receive a copy of the complaints procedures within 24 hours of admission. Clients have the right to a comment, complaint and grievance procedure without fear of denial of service or other punitive measures and receive a fair response from the Center within a reasonable amount of time. Complaints may be brought about any part of services including modifying, suspending or terminating service.

8. **Humane Environment, Abuse, Neglect and Exploitation:** Clients have the right to a humane environment that provides reasonable protection from harm and privacy for personal needs which is free from physical, mental or sexual abuse, neglect and exploitation.

9. **Dignity:** Clients have the right to be treated with respect, consideration and recognition of their dignity, individuality and personal privacy. Clients have the responsibility to render the same to the provider to receive personal care and treatment in safe, clean surroundings. Clients have the right to treatment, care and settings that is considerate and respectful of the client's beliefs and values.

10. **Peers serving as employees or volunteers:** Clients have the right to serve as peer support specialists as either an employee or volunteer. Clients have a right to integrate peer work into a care plan.

11. **Fees and Payments:** The right to know in advance about the cost and conditions of payment for treatment, including limitations on the duration of services.

12. **Explanation of Rights and Responsibilities:** The right to receive a complete explanation of these rights in clear, non-technical terms and in a language the client understands within 24 hours of admission.

    The right at the time of admission or at anytime upon request throughout the span of service, to have a staff member inform the client of their client rights, and to have any questions about these rights answered.

    The right to receive a written copy and explanation of these client rights and the grievance procedure at the time of admission or at anytime upon request throughout the span of service including the funding sources address and phone number.

13. **Detention:** The right not to be detained against the client/consenter's will.

14. **Conditions for Service:** The right to receive services free from conflict of interest or dual relationships. If now or at anytime while receiving services here a client is involved in a partner/spouse relationship with a staff member or member of the board of directors, services should be discontinued and three referrals will be given. Since dual relationships between clients and the Center staff and volunteers can interfere with the therapeutic process, the relationship needs to be over for at least one (1) year before services can resume.

RESPONSIBILITIES

1. **Confidentiality:** As a client you have the responsibility to never repeat to anyone else the name or identifying information of any other clients you see at the Center. All clients deserve the same privacy from each other that the staff gives you.

2. **Information:** As a client you have the responsibility to inform your Therapist or Case Manager when you do not understand instructions or information that you receive. If you need someone to help you complete forms, explain an instruction or read or interpret for you, staff needs to know that from you. As a client you have the responsibility to keep your Case Manager or Therapist informed about the quality, appropriateness and timeliness of services that you are receiving. The Center tries to provide services that fit you and your situation. If you have had problems with the services here you have options. Tell your Therapist or Case Manager, talk to their supervisor or fill out an anonymous survey in the lobby. As a client you have the responsibility to provide accurate and complete information about your history and changes in your condition during services.

3. **Appointments:** As a client you have the responsibility to keep your scheduled appointments with your Therapist or Case Manager and other service providers and to notify them when you need to cancel or reschedule. All counseling services are scheduled by appointment only. If you cannot get to your appointment, please call at least 24 hours in advance. In emergencies, call as soon as you can so that we may give the time to another person who may be waiting for service.

The usual session charge will be applied for appointments not kept or appointments that are canceled less than 24 hours in advance. Clients who need to cancel a Monday appointment may leave a message with the answering service 24 hours in advance to avoid charges.

4. **Collaborative Effort and Follow Through:** As a client you have the responsibility to complete those activities that you agree to do and to notify your Therapist or Case Manager when you are unable to do so. The Center staff works hard with you. If you have agreed to make phone calls or check up on something, please complete your task. If you are unable to do so, please let your Therapist or Case Manager know as soon as possible so they may help you. As a client you have the responsibility to accept the consequences of the outcome or no outcome if you do not do your part.
5. **Obtaining Services on Your Own:** As a client you have the responsibility to notify your care manager or Therapist of services that you obtained by yourself. So we will not spend time working on a service you already have, please let your Therapist or Case Manager know as soon as possible.
6. **Needs:** As a client you have the responsibility to communicate your needs to and ask questions of your Case Manager or Therapist as quickly as possible, understanding that your Case Manager or Therapist may not be able to satisfy "last minute" requests. Many agencies close at 5:00 pm. While you can reach the Center by phone after that time, we may not be able to get in touch with another agency to help you. It is also important to keep your requests reasonable. It is not always possible to fulfill requests, particularly housing. For example, there are no sources of free apartments.
7. **Conduct:** As a client you have the responsibility to conduct yourself appropriately when interacting with staff and other clients. Inappropriate behavior includes intoxication, threats, harassment, sexual advances or comments, and physical and verbal abuse. Weapons are not allowed in any the Center buildings. If discovered, they may be turned over to law enforcement. Smoking is not permitted in the Center's buildings. As a client you have the responsibility to give truthful information to your Therapist or Case Manager. Anyone who knowingly gives false information to their Therapist or Case Manager may lose the right to receive grant funded services at the Center. As a client you have the responsibility to keep the Center free of political candidate campaigning. No campaign materials (T-shirts, literature, cards, buttons, etc.) or speeches advertising a candidate for an active election are allowed in any the Center facility.
8. **Documentation:** As a client you have the responsibility to provide documentation needed to qualify you for services before services can be provided, such as, proof of where you live, current proof of income, and proof of HIV status if applicable. In order to provide you with grant funded services, your Therapist or Case Manager must show proof that you qualify.
9. **Fees:** As a client you have the responsibility to pay the fees you have agreed to and to notify your therapist if your insurance plan, or insurance company or income has changed. You will be responsible for paying any increase, if applicable, of co-insurance or copays incurred due to a delay in informing us of the insurance change. The Center has a sliding scale and tries to work with you in setting a reasonable fee. Once you agree to a fee, we count on that.

____ ______/______/______
Client's Signature Date

____ ______/______/______
Parent, Guardian or Authorized Representative's Signature Date

13.3.5 CLIENT SURVEY – RW TITLE I CHEMICAL DEPENDENCY TREATMENT

Client Name: ______________________________________
Date: ____/____/_____ 11-Character Client Code: ___________________________

Which Assessment? Circle one: Baseline 2 Months

Please read the following questions and circle the best answer:

1. In the past two weeks, how often have you had someone you could talk to about your problems with alcohol and drug abuse or someone who could give you useful advice about dealing with alcohol and drug abuse?

   1) Never
   2) Rarely
   3) Sometimes
   4) Most of the time
   5) All of the time

2. In the past two weeks, how would you rate your ability to cope with problems and troubles with drug and alcohol abuse?

   1) Poor
   2) Fair
   3) Good
   4) Very good
   5) Excellent

3. In the past three months, how many times have you been hospitalized or visited the emergency room (ER) due to HIV-related complications?

   1) None
   2) One time
   3) Two times
   4) Three times
   5) Four or more times

4. In the past two weeks, please estimate how many community support group meetings you have attended.

   1) None
   2) One to two meetings
   3) Three to five meetings
   4) Six to ten meetings
   5) Eleven or more meetings

5. In the past two weeks, please estimate how many days you have abstained from alcohol and drugs.

   1) None
   2) One to four days
   3) Five to nine days
   4) Ten to thirteen days
   5) I have abstained every day

Thank you. Your answers will help us to monitor and improve our services.

____

Staff Name: ________________________

Completed Treatment Yes No

Data Entry: _______________________

3.4.3.5 WAY OUT RECOVERY PROGRAM AGREEMENT – CLIENT RESPONSIBILITIES & INFORMED CONSENT

I, (Client Name):___________________________________ am requesting enrollment in the Way Out Recovery Program of the Montrose Center. As a participant in this program, I understand and agree to the following requirements:

- I agree that at no time during my participation in the program will I use any mind altering chemicals including but not limited to alcohol, marijuana, cocaine, crack, crystal, poppers, heroin, diet pills, Ecstasy etc.
- I understand that the program requires drug and alcohol screening via urinalysis (UA)/breath tests and that refusal may result in my being discharged from this program.
- I agree to pay the cost of the required alcohol and drug screening tests, and that grant subsidies and insurance may not cover these costs. I understand that the payment for two (2) drug screens and two (2) alcohol screens will be due at the time of orientation at the currect cost of $5/test; and that if additional tests are required, payment will be due at the time of each test. I understand that if I cannot pay the costs at the time they are due, I may request a payment arrangement.
- I agree to maintain confidentiality at all times. I will not disclose any names or information shared by other participants outside of the group. Further, I agree to bring any outside discussion of group concerns back to the group.
- I understand that I am financially responsible for my portion of the cost for the program regardless of my length of participation unless prearranged otherwise and regardless of whether I terminate the program under unfavorable circumstances. I understand that I am responsible to pay my balance in full for the services rendered up to the time of my discharge calculated on a prorated basis. I understand that I must notify my Therapist of any change in my income or health insurance status as soon as that information is known to me. I understand that if a portion of my treatment is being covered by insurance benefits that I am responsible for any difference in treatment costs not reimbursed and that the consumer percentage cost quoted to me is only an estimate and that DSHS-SAS and Ryan White will not pay for services beyond my deductible amount. Following that, I will need to be in contact with my insurance provider to continue payment of my treatment services.
- I understand that I am responsible for notifying the group facilitator by telephone if I am unable to attend any group session, and that individual appointments must be canceled with a minimum of 24 hours’ notice except in the case of extreme emergencies approved by the Therapist.
- I agree to a suggested eight (8) weeks participation in the Intensive Phase and if desired/required, eight weeks in the Relapse Prevention Phase of the program. I understand I may be asked to participate in additional weeks in order to successfully complete treatment. I understand that attendance in a 12-step or other community-based recovery support group is mandatory.
    - Intensive Outpatient Program: three (3) times per week
    - Relapse Prevention: two (2) times per week
- I understand that in order to qualify for the Relapse Prevention Phase of the program, that I must successfully complete the Intensive Phase, and/or a licensed inpatient program, or have three (3) months without using mind altering chemicals.
- I understand that if I accrue more than the total number of unexcused absences (listed below) from scheduled group activities (excluding those for medical reasons, acts of nature, or pre-arranged with my individual Therapist) that I am subject to suspension from group participation.
    - Intensive Outpatient Program: four (4) absences in an eight (8) week period.
    - Relapse Prevention Program: three (3) absences in a twelve (12) week period.

Client's Name: ______________________________

- I understand that if I accrue the number of unexcused absences in a row outlined below from scheduled group activities that I am subject to suspension from group participation.
  - Intensive Outpatient Program: three (3) absences in a row.
  - Relapse Prevention Program: two (2) absences in a row.
- I agree to arrive to group on time and will call to notify facilitator if I am running late. I understand that if I do not call I will not be admitted after 6:05 pm. I will not be admitted to group if I arrive after 6:20 pm.
- I agree to be verbally and physically respectful of staff and of other group members.
- I understand that there are opportunities, specifically Family of Choice Night, for my family of choice to be involved in my treatment with my consent.
- I understand that dual relationships, particularly business and financial arrangements, cohabitation, dating or sexual relationships with any other group member, is not allowed and is grounds for suspension and/or discharge from the Program.
- I understand that if I relapse during my participation in this program, that I may be suspended from group activities. Repeated relapse, regardless of group status, may result in my being discharged from the program for a period of no less than ninety (90) days.
- I understand that if I am suspended from group activities that my re-entry into full participation will require the approval of both my individual Therapist and the Program Coordinator.
- I understand that if I have excessive unexcused absences from my Individual therapy sessions that I may be discharged from the program.
- I understand that before I am admitted to the program I must provide a list of all prescribed medications and I am required to report any changes in my medication regime to my primary Therapist.
- I understand that revealing or sexually provocative dress is not permitted in group.

Informed Consent

- The philosophy of the Montrose Center is that substance use disorder is a chronic progressive disease that left untreated will lead to serious medical and mental health consequences. The *risks* of not receiving treatment include but are not limited to: serious damage to all systems of the body (that could lead to death), mental illness and incarceration. People who suffer from substance use disorder often experience loss of employment, family, significant relationships and personal integrity. In sum, substance use disorder left untreated deprives people of a quality of life that could be afforded to them if the disease were not present.
- The good news is substance use disorder is treatable. The Montrose Center offers a sensitive treatment environment targeted to lesbian, gay, bisexual and transgendered individuals. During the course of treatment participants will learn the biological, social and individual factors contributing to substance use disorder and the process of recovery. The *benefits* of substance use disorder treatment include but are not limited to: a life drug free that would lead the way to improved coping skills, mended relationships, self-esteem and broader life choices.
- The truth is recovery from substance use disorder is difficult. Participants involved in treatment may experience emotional distress when they begin to examine their own personal histories or attempt to learn new ways of coping without drugs or alcohol. The possible *side effects* of treatment include but are not limited to a heightened sense of anxiety, a more intensive level of feelings and a period of adjustment in daily living. For some, there may be a disruption in personal relationships, especially those where drug or alcohol abuse has been central to the relationship.

- Substance use disorder can be life threatening so it is important that people seeking treatment be assessed for the correct level of care. The intake Therapist will provide information on any generally accepted *alternatives* and whether an alternative method might be suitable. Some generally accepted alternatives to outpatient treatment some of which include: another outpatient program, another level of care, residential treatment, hospital-based day treatment, hospital inpatient treatment, a private practitioner or a support group (12-step or similar). A list of referrals will be given on request or when alternatives are appropriate.
- I understand that as a participant with grant funding, I am eligible to receive the same services as other clients including: (a) drug free outpatient group and/or individual counseling, (b) referral and/or counseling services for my family members where appropriate, (c) follow-up contact sixty (60) days after discharge from this program, and (d) referral for continued treatment should I terminate from this program prior to the end of scheduled treatment.
- I understand the different levels of the outpatient program and further understand that any clinical staff member at the Montrose Center may provide these services. Those staff members may have any of the following credentials: Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Chemical Dependency Counselor, Counselor in Training or graduate student intern. I further understand that the credentials of a particular staff member will be furnished to me upon request.
- I understand that, if my services are funded by DSHS, my social security number, name and treatment information will be entered into the Behavioral Health Integrated Provider System managed by the Texas Department of State Health Services. I understand that using my social security number is voluntary and that receipt of services is not contingent on submission of this information. Federal statutes protect my confidentially of this and any other identifying information in my file. If I have a concern about the Center transmitting that data, I will consult my counselor.
- I understand that I am being treated for ___________________________________. The Center staff recommends that I participate in outpatient treatment for a minimum of ________ weeks.
  - My primary Therapist will be ______________________________________

==

By signing this form I am consenting to substance use disorder treatment. I understand: the specific condition to be treated and level of care to be received; the programs services and treatment process; the expected benefits of the treatment; the probable health and mental health consequences of not consenting; side effects and risks associated with treatment and generally accepted alternatives.

I have been provided with the estimated daily charge, including an explanation of any services that might be billed separately; the qualifications of the staff who will provide the treatment; the name of the primary Therapist; expectations for client participation, the Statement of Client Rights and Responsibilities and Complaint/Grievance Procedures. I have been given a client handbook.

I understand the program rules and have received a copy of them. I understand the consequences of violating the rules as explained in the contract. Violation can include being expelled from the program. I have had the Program's philosophy and treatment objectives explained. They have been discussed with me and I have been able to get answers to any questions I have about them. I have been given a list of resources for me and my family.

_________________________ _________________________ ____/____/____
Client's Name Client's Signature Date

__________________________ _____/_____/_____ _____________________________ ______/______/______
Guardian's Signature Date Therapist's Signature Date

18.1.3.5 CONSENT FOR THE RELEASE/REQUEST OF CONFIDENTIAL INFORMATION FOR FOLLOW-UP

I, ________________________________, authorize the Montrose Center to disclose to:

______________________________________ Name	______________________________________ Name
______________________________________ Address	______________________________________ Address
______________________________________ City, ST, Zip	______________________________________ City, ST, Zip
_____/_____-_______ Home Phone _____/_____-_______ Work Phone	_____/_____-_______ Home Phone _____/_____-_______ Work Phone

information regarding my status of chemical dependency and other treatment at the Center, for the purpose of garnering follow-up information. I understand the above named persons will be contacted only in the event that the staff of the Center is unsuccessful in contacting me.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, §42 CFR, Part 2; HIPAA Privacy Act §45 CFR 160-164, §33 of Public Law 91-616 as amended by Public Law 93-282; Texas Health and Safety Code §81.103 HIV records and Chapter 611 mental health records, and Texas Administrative Code §379.2011 family violence records and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as valid as the original. This consent expires one (1) year after my last date of service (individual, family, or group session) at the Center, or ____ other ______________________________________ unless I revoke it as provided for above.

______________________________ ____/____/____ ______________________________

Client's Signature — Date — Parent, Guardian, or Authorized Representative's Signature

4/13, 3/15

3.4.3.10 MEETING ATTENDANCE VERIFICATION

The following person has been asked to provide verification of attendance at AA, NA, CA and/or other recognized support meetings. Please provide that verification by signing below.

Name ____

Date	Group Name/Location	Chairperson's Signature

2.5.3 CONSENT FOR SERVICES, CPCDMS, AIRES & CMBHS

Client 11-Character Code												ARIES Code		

I, ____ wish to receive services provided by the Montrose Center, an agency participating in the ***Centralized Patient Care Data Management System*** (***CPCDMS***) for Ryan White funded services and maintained by Harris County Public Health Services - HIV Services, ***AIDS Regional Information and Evaluation System (ARIES)*** State Services funded services and maintained by Department of State Health Services – HIV/STD and ***Clinical Management of Behavioral Health Services(CMBHS)*** for DSHS-SAS funded services maintained by the Department of State Health Services – Substance Abuse Services**.**

.I understand that key activities include assessing my eligibility and needs; providing me with requested services; networking with other participating agencies within the ***CPCDMS, ARIES, and CMBHS,*** *as applicable,* and ensuring the coordination, monitoring and quality of services received.

I understand that my identity and my participation in the ***CPCDMS, ARIES, and CMBHS*** are confidential. I understand that no information or records associated with my case will be knowingly released to anyone or any agency that is not currently participating in the ***CPCDMS, ARIES*** or ***CMBHS*** without my informed written consent, or a subpoena, court order or legal statute. Furthermore, I understand that an additional consent for the release/exchange of information to verify my eligibility will be required ***before*** I can receive Ryan White Part A, Department of State Health Services – HIV/STD or Substance Abuse Services funded services.

By my signature below, I give permission for information pertaining to my demographics and services to be entered into the ***CPCDMS, ARIES*** *and, as applicable,* ***CMBHS***. The centralized databases can only be accessed by authorized personnel to assess the system's provision of services for planning, program development, statistical reporting and research purposes. **No identifying information, such as my name, address or social security number will be stored at the Ryan White central site, however, authorized data system administrators may view such information stored at the Center site. If your services are funded by DSHS-SAS, identifying information is stored at the DSHS-SAS central site. If you have concerns about this data being entered into one or both of these systems, please let your case manager know. I understand that using my name and social security number is voluntary and that receipt of services is not contingent on submission of this information.**

I am giving this consent of my own free will. This consent will remain in effect until I provide a written statement revoking my consent. I agree to allow information about me and my services to be entered into the CPCDMS/ARIES. I agree to allow information about me and my services to be entered into CMBHS.

I fully release and hold the entity(ies) administering the funding for the service(s) listed above; Harris County Public Health & Environmental Services, that is the entity responsible for overseeing and maintaining the ***CPCDMS***; Department of State Health Services – HIV/STD or Substance Abuse Services; that is the entity responsible for overseeing and maintaining the ***CMBHS*** and ***ARIES,*** and The Resource Group, *as applicable*; the Montrose Center; their Officers, Directors, Board Members, employees and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorneys, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I was given a copy of the Client Handbook which includes my Client Rights and Responsibilities, the Complaint/Grievance Policy, HIPAA Privacy Act notices and procedures provided by the Montrose Center, Department of State Health Services – HIV.STD or Substance Abuse Services and Harris County Public Health & Environmental Services, HIV Services office. I was offered an opportunity to discuss them in a language and format I understand and I agree to abide by them.

___________________________________ _____/_____/_____ ___________________________________

Client's Signature Date Parent, Guardian, or Authorized Representative's Signature