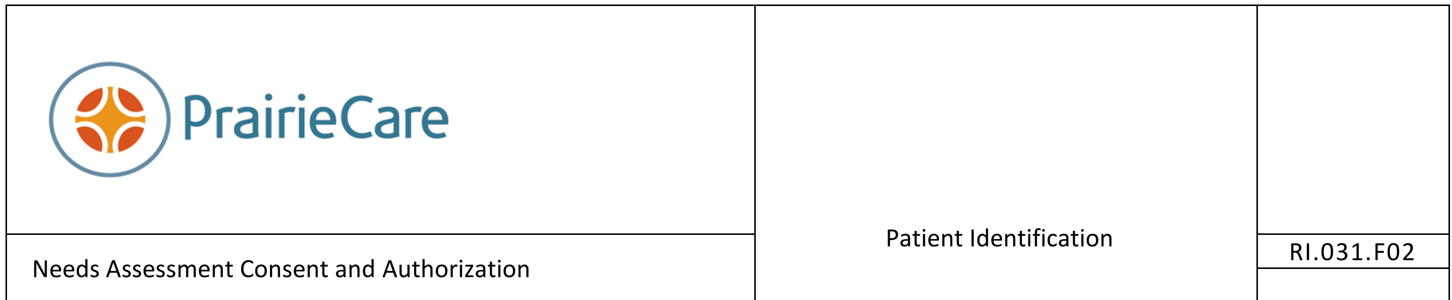

Needs Assessment Consent and Authorization	Patient Identification	RI.031.F02

Consent to Assessment: The Needs Assessment consists of an interview with you and family members, if present, by a Needs Assessment Counselor. The counselor looks at the current problems you are describing and assesses your mood, behavior and thinking. The counselor may then confer with our on-call psychiatrist to determine the most appropriate level of care and reviews the recommendations with you.

_______**Health Care Education:** PrairieCare is a teaching organization. With your permission, a student may sit in the assessment.

_______**Acknowledgement that Patient Information may be released in the case of a medical emergency:** By signing below, you acknowledge PrairieCare may release confidential medical information as required or permitted by law in emergency medical situations, including but not limited to confidential medical information which may include **drug / alcohol abuse, HIV status, or psychiatric treatment**. "Emergency medical situations" includes any time we believe you pose a risk of harming yourself or another.

Other than as stated above or authorized by law, PrairieCare does not release patient-identifiable medical information outside this institution without your further written authorization.

_______**Acknowledgement that PrairieCare may withhold medical records and/or psychotherapy notes from you**: The safety and well being of our patients is our highest priority. In accordance with State and Federal Law, we may refuse to provide you with some/all of your medical records or psychotherapy notes if we reasonably believe releasing the information will be detrimental to your physical or mental health, or is likely to cause you to inflict harm upon themselves or other(s). This includes withholding information from parents/guardians when we reasonably believe providing the information will be detrimental to the physical or mental health of our patient. This decision is at the sole discretion of your provider.

I have read and understand the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the above conditions for care at PrairieCare. If I am not the patient, I certify that I am authorized by law to agree to these conditions on the patient's behalf. A copy of this form is as effective and valid as the original.

Note: Parent/Guardian consent required for patients under 16 unless married, given birth, living apart and managing own finances, or Alcohol or CD treatment.

Patient's Name	Signature of Patient / Parent / Authorized Agent
Witness	Date
Account #	Medical Record #