CHILDREN'S HEALTH

CONSENT
CMC82900-001NS Rev. 6/2019

Consent for Behavioral Health Screening and Treatment (School Based Recommendation)

☐ Patient Name: ______________________________ Date of Birth: __________

☐ School Name: ______________________________

Behavioral Health Care Manager: ______________________________

I am the Patient or Legally Authorized Representative (e.g. mother / father / guardian) of the Patient. At the recommendation of the Patient's school or pediatrician as part of Patient's treatment plan, I request and consent for Patient to be seen by a Behavioral Health Care Manager (BHCM), who is a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist at a Children's Health System of Texas hospital, facility, entity or program ("Children's Health"). I understand that Patient's treatment by a Children's Health BHCM is specific to behavioral health assessment, short-term treatment, case management and / or consulting services and is not a substitute for medical treatment. The BHCM working with the Patient will keep me informed regarding the behavioral health services being provided and the anticipated duration of services. I understand that Children's Health is a separate provider of services and the Children's Health BHCM is not an employee or under the control of Patient's school. I understand, the initial telephonic assessment and ongoing telephonic case management are provided at no cost to me and my child. No services which generate a bill will be provided to me or my child without my written permission.

The Children's Health behavioral health services are intended to support the behavioral health needs of the Patient. The BHCM working with the Patient will not complete evaluations for the purpose of determining fitness for parental custody and will not make recommendations regarding custody. it is agreed by signing this consent that the Patient and the Patient's legal guardians will not call or subpoena the Children's Health BHCM to testify in a custody dispute.

I understand that Children's Health, the BHCM, Patient's school and other providers may share, exchange and disclose information about Patient including Patient's protected health information (PHI) for treatment, payment and operational purposes and I authorize such use and disclosures by electronic and other methods. This authorization includes the disclosure of Patient's diagnoses, history, medical condition and / or treatment and may include information related to genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment.

I understand that I can revoke this consent at any time by providing notice to the Children's Health BHCM.

______________________________ __________ __________
Signature of Patient / Legally Authorized Representative | Date | Time

______________________________ ____________________
Printed Name of Patient / Legally Authorized Representative | Relationship to Patient

______________________________ __________ __________
Signature of Witness / Interpreter | Date | Time

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Printed Name of Witness / Interpreter

Schools / PCPs / Clinics:
Please fax to 214-867-5383 with demographic page - BH Hotline 844-856-6926