995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

CONSENT TO RECEIVE PRESCRIBED AND/OR PSYCHOTROPIC MEDICATIONS

The Mental Health Association, Inc., asks your permission to dispense medications prescribed for you by your treating, prescriber while you are a participant in this program. The purpose of dispensing any such medications is to treat specific acute or chronic psychiatric problems that have been diagnosed by your psychiatrist or any consulting licensed psychiatrist.

While taking psychotropic medication, arrangements will be made for you to be seen regularly by your prescribing psychiatrist.

In all cases, the following information will be given to you at the time that the prescription is written: purpose of each medication; benefits it will produce and the likelihood of their occurring; the possible side effects of each medication and the likelihood of occurring; methods to minimize such side effects; other possible treatments that have been tried or that would be tried; and the reason for choosing the prescribed medication instead.

Medications will be given only according to the written prescription of the physician. The staff dispensing medications will be trained in and follow the procedures for the safe and accurate dispensation of medications and for the accurate documentation in compliance with DMH/DDS/DPH regulations and in accordance with MHA's policies.

I hereby consent to the dispensation of medications as described above. I give consent voluntarily without threat of punishment or promise of special reward. I have been given an opportunity to fully discuss the treatment and to have questions answered. I have also been offered a copy of this form. I understand that I may withdraw this consent at any time without fear of punishment.

❑ psychotropic ❑ other prescribed ❑ both

The Specific Plan(s) for Dispensing Medication(s) to: _____ _____ is/are
Participant Name

_____ _____
Date Signature

I consent to have an annual physical exam by my primary care provider as required by DMH/DDS/DPH regulations for all persons receiving psychotropic medications.

_____ _____
Date Signature

I have fully explained the above information in a manner understood by the consenting party and have answered all questions to the best of my ability. It is my opinion that consent has been freely and knowingly given.

_____ _____
Date Signature and Title of Person Obtaining Consent

a Protected health information ("PM") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

Rev.07/13