MENTAL HEALTH ASSOCIATION, INC.

995 Worthington Street, Springfield, MA 01109
Telephone (413)734-5376 Fax (413)737-7949 TTY (413)785-5288

MEDICAL SERVICES AND HOSPITAL EMERGENCY CONSENT

I, _____, the undersigned, authorize the staff to secure medical services as they appear to be needed or in the case of any apparent medical emergency involving _____.

Staff will contact family/guardian, as soon as possible.

I also, hereby agree to be completely responsible for any fees or charges necessitated by medical services, medication rendered to or prescribed for the above named individual. I further understand that MHA will not be responsible for medical expenses incurred while the above named individual is participating in a program of the Mental Health Association, Inc.

In case of any apparent medical emergency, I (guardian name) _____ , bearing relation of _____ to (participant's name)_____hereby give permission to the authorized physician in the hospital emergency room to perform the necessary treatment which will alleviate the emergency situation. I understand that I may request a full explanation of any treatment as well as the risks, benefits and alternative options.

_____ _____
Signature of Participant Date

_____ _____
Signature of Parent/Guardian/Legal Representative (if applicable) Date

_____ _____
Signature of Witness Date

***Protected health information ("PHI") 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.P.R. 164.508.**