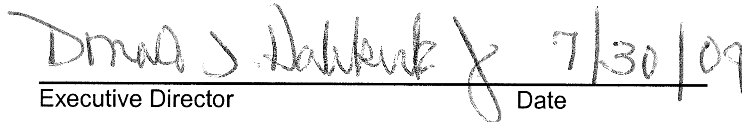
MCCMH MCO Policy 9-604

(was MCCMH Policy 9-06-040)

Chapter: **RECIPIENT RIGHTS**
Title: **RELEASE OF ORAL / VERBAL COMMUNICATIONS**

Prior Approval Date: 8/28/02
Current Approval Date: 7/30/09

Approved by: BOARD ACTION



Executive Director Date

I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health (MCCMH) Board regarding the release of oral/verbal communications of recipients of services by MCCMH network providers.

II. Application

This policy shall apply to all directly-operated and contract network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board that information obtained from a conversation with a recipient shall be disclosed only with the prior written consent of the recipient, parents (or parent with legal and physical custody), or an empowered guardian, in accordance with this policy.

IV. Definitions

A. Public News Media
Publications including but not limited to newspapers, magazines, books and other printed materials produced by the public press, business or industrial firms, non-profit

associations or public agencies (including mental health agencies); or communication systems capable of transmitting photographs or sound via air or cable, e.g., television, radio or fax.

V. Standards

A. Prior to printing information obtained from a conversation with a recipient in any publication (e.g., annual reports or newsletters) or forwarding to the public news media, prior written consent shall be obtained from the recipient, parents (or parent with legal and physical custody), or legally empowered guardian, in accordance with this policy.

B. Completed consent forms shall be placed in the recipient's clinical record.

C. Consent given on behalf of a minor is effective only during his/her minority. Once a minor recipient turns 18, any prior parental consent is void and the consent of the now adult recipient is required to continue using the recipient's oral/verbal communication.

D. Written consent for the release of oral/verbal communications shall contain:

1. Identification of organization to whom the information will be released;

2. Statement of intended use or purpose;

3. Statement of any risk that such consent could generate e.g., risk to confidentiality, privacy;

4. Statement approving or not approving the use of the recipient's full name;

5. Statement indicating recipient has had opportunity to ask and have questions answered;

6. Statement indicating the date by which the recipient may withdraw consent and that once released, the information may be republished;

7. Statement that the withdrawal of consent will not jeopardize the receipt of services.

8. Dated signature of the recipient, if 18 years of age or older, or the parent(s) of a minor recipient, or an empowered guardian, and a witness.

E. Written permission to release oral/verbal communication shall be secured and shall document the recipient's consent. (See example MCCMH #281, Exhibit A.)

F. This policy shall not be construed to interfere with the rights of recipients who wish to provide information directly to third parties, including the public media. Rather, these procedures shall be carried out with the singular purpose of protecting each MCCMH recipient's rights to confidentiality.

VI. Procedures

A. None.

VII. References / Legal Authority

A. Michigan Mental Health Code, MCL 330.1748

VIII. Exhibits

A. Permission to Release Oral / Verbal Communication, MCCMH #281 (example)

MACOMB COUNTY COMMUNITY MENTAL HEALTH

Permission to Release Oral / Verbal Communication

I, ______________________________ give permission for Macomb County Community Mental Health to release the information I verbally communicated to

______________________________ on ______________
name title date

to ______________________________
name or organization

I understand that this information will be used only for the following purpose(s):

____

____

____

I consent to having my full name used in this project. **YES** [ ] **NO** [ ]

I understand that this consent may jeopardize my right to confidentiality as I may be identified as a recipient of services provided by a Macomb County Community Mental Health provider.

I understand I may withdraw consent if I do so by ______________________________

and that once released, the information may be republished by ______________________________

I understand that withdrawal of consent will not jeopardize my services. Any questions I have about this permission form have been explained to my satisfaction.

____
Consumer signature date

____
Witness signature date

____
Parent / Guardian signature (if applicable) Relationship date

Permission to Release Oral / Verbal Communication, MCCMH #281 (rev. 7/02), MCCMH MCO Policy 9-604, Exhibit A