Unleashing Potential, LLC

11100 Liberty Road, Suite G
Randallstown, MD 21133
www.unleashing-potential.org
info@unleashing-potential.org

Date: _____

Participant Emergency Contact Form

Please complete this entire document

Participant Name: _____ Social Security Number: _____

Address: _____

Cell: _____ Alternate Phone: _____ Email: _____

Parent/Guardian (if applicable): _____

Address: _____

Cell: _____ Contact Email: _____

In Case of Emergency, please list two (2) people over the age of 18 who can be contacted:

Name: _____ Contact Number: _____

Address: _____

Other Number: _____ Contact Email: _____

Name: _____ Contact Number: _____

Address: _____

Other Number: _____ Contact Email: _____

Primary Health Care Provider (please mark if you do not have one ☐):

Clinic Name: _____ Doctor Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Mental Health Provider:

Clinic Name: _____ Therapist Name: _____

Address: _____

Phone Number: _____ Email: _____

Known Allergies: _____

RELEASE OF INFORMATION

Emergency Contact

NOTE: This form is valid for one year from the date signed unless the participant and/or participant representative decides to void this release of information for any given reason prior to the one-year expiration date.

Participant Name: _____ SS#: _____ DOB: _____

Release To: _____

Emergency Contact

Phone Number of Addressee: _____

I, _____ voluntarily give my consent to authorize representatives of UNLEASHING POTENTIAL, LLC and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and UNLEASHING POTENTIAL, LLC in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at UNLEASHING POTENTIAL, LLC.

Addressee to Release Information to UNLEASHING POTENTIAL, LLC:

☐ Verbal Exchange between the above-named entity and UNLEASHING POTENTIAL, LLC
☐ Intake Assessment and Treatment Plan
☐ Medication List
☐ Quarterly Review
☐ Transfer/Discharge Summary
☐ Physical Examination Records (within one year of date signed)
☐ Physician Recommendation for Community Rehabilitation Services
☐ Other: _____

UNLEASHING POTENTIAL, LLC to Release to Addressee:

☐ Intake Assessment
☐ Entitlement Information
☐ Rehabilitation Assessment
☐ Treatment Plans (ITP, ITRP and Review)
☐ Psychiatric Assessment, Notes, Medication Log
☐ Transfer/Discharge Summary

Participant/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date Release of Information Expires: 1 year from date signed

☐ Notice of Revocation: As of today I, _____, revoke consent from the above entity. I have revoked consent as of ____/____/____ ☐ In person ☐ By Phone ☐ In Writing

RELEASE OF INFORMATION
Mental Healthcare Provider

NOTE: This form is valid for one year from the date signed unless the participant and/or participant representative decides to void this release of information for any given reason prior to the one-year expiration date.

Participant Name: _____ SS#: _____ DOB: _____

Addressee (Name): _____
Current/Prior Mental Health Provider

Phone Number of Addressee: _____

I, _____ voluntarily give my consent to authorize representatives of UNLEASHING POTENTIAL, LLC and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and UNLEASHING POTENTIAL, LLC in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at UNLEASHING POTENTIAL, LLC.

Addressee to Release Information to UNLEASHING POTENTIAL, LLC:
☐ Verbal Exchange between entity and UNLEASHING POTENTIAL, LLC
☐ Intake Assessment and Treatment Plan
☐ Medication List
☐ Quarterly Review
☐ Transfer/Discharge Summary
☐ Physical Examination Records (within one year of date signed)
☐ Physician Recommendation for Community Rehabilitation Services
☐ Other: _____

UNLEASHING POTENTIAL, LLC to Release to Addressee:
☐ Intake Assessment
☐ Entitlement Information
☐ Rehabilitation Assessment
☐ Treatment Plans (ITP, ITRP and Review)
☐ Psychiatric Assessment, Notes, Medication Log
☐ Transfer/Discharge Summary

Participant/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date Release of Information Expires: 1 year from date signed

☐ Notice of Revocation: As of today I, _____, revoke consent from the above entity. I have revoked consent as of ____/____/____ ☐ In person ☐ By Phone ☐ In Writing

RELEASE OF INFORMATION

Primary Care Physician (PCP)

NOTE: This form is valid for one year from the date signed unless the participant and/or participant representative decides to void this release of information for any given reason prior to the one-year expiration date.

Participant Name: _____ SS#: _____ DOB: _____

Addressee (Name): _____

Primary Care Physician

Phone Number of Addressee: _____

I, _____ voluntarily give my consent to authorize representatives of UNLEASHING POTENTIAL, LLC and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and UNLEASHING POTENTIAL, LLC in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at UNLEASHING POTENTIAL, LLC.

Addressee to Release Information to UNLEASHING POTENTIAL, LLC:

☐ Verbal Exchange between entity and UNLEASHING POTENTIAL, LLC
☐ Intake Assessment and Treatment Plan
☐ Medication List
☐ Quarterly Review
☐ Transfer/Discharge Summary
☐ Physical Examination Records (within one year of date signed)
☐ Physician Recommendation for Community Rehabilitation Services
☐ Other: _____

UNLEASHING POTENTIAL, LLC to Release to Addressee:

☐ Intake Assessment
☐ Entitlement Information
☐ Rehabilitation Assessment
☐ Treatment Plans (ITP, ITRP and Review)
☐ Psychiatric Assessment, Notes, Medication Log
☐ Transfer/Discharge Summary

Participant/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date Release of Information Expires: 1 year from date signed

☐ Notice of Revocation: As of today I, _____, revoke consent from the above entity. I have revoked consent as of ____/____/____ ☐ In person ☐ By Phone ☐ In Writing

RELEASE OF INFORMATION

School

NOTE: This form is valid for one year from the date signed unless the participant and/or participant representative decides to void this release of information for any given reason prior to the one-year expiration date.

Participant Name: _____ SS#: _____ DOB: _____

Addressee (Name): _____

School

Phone Number of Addressee: _____

I, _____ voluntarily give my consent to authorize representatives of UNLEASHING POTENTIAL, LLC and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and UNLEASHING POTENTIAL, LLC in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at UNLEASHING POTENTIAL, LLC.

Addressee to Release Information to UNLEASHING POTENTIAL, LLC:

☐ Verbal Exchange between Addressee and UNLEASHING POTENTIAL, LLC
☐ Intake Assessment and Treatment Plan
☐ Medication List
☐ Quarterly Review
☐ Transfer/Discharge Summary
☐ Physical Examination Records (within one year of date signed)
☐ Physician Recommendation for Community Rehabilitation Services
☐ Other: _____

UNLEASHING POTENTIAL, LLC to Release to Addressee:

☐ Intake Assessment
☐ Entitlement Information
☐ Rehabilitation Assessment
☐ Treatment Plans (ITP, ITRP and Review)
☐ Psychiatric Assessment, Notes, Medication Log
☐ Transfer/Discharge Summary

Participant/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date Release of Information Expires: *1 year from date signed*

☐ Notice of Revocation: As of today I, _____, revoke consent from the above entity. I have revoked consent as of ____/____/____ ☐ In person ☐ By Phone ☐ In Writing

RELEASE OF INFORMATION

Medicaid: Optum

NOTE: This form is valid for one year from the date signed unless the participant and/or participant representative decides to void this release of information for any given reason prior to the one-year expiration date.

Participant Name: _____ SS#: _____ DOB: _____

Addressee (Name): Medicaid: Optum

I,_____voluntarily give my consent to authorize representatives of UNLEASHING POTENTIAL, LLC and the addressee to exchange information as indicated below. This information is to be kept confidential and may not be released to any other agency or individual(s) without my signed consent. The purpose of this information exchange is to provide continuity of care and to assist the addressee and UNLEASHING POTENTIAL, LLC in my treatment. In no way will information exchanged be used to discriminate against me or to deny me from receiving services at UNLEASHING POTENTIAL, LLC.

To exchange with one another the following information:

- ☐ Assessment
- ☐ Treatment
- ☐ History and Plan
- ☐ Physical; Medication Administration Records
- ☐ Progress Notes
- ☐ Lab Results and Test Results
- ☐ Discharge Summary
- ☐ Care Plan
- ☐ Vocational and/or Educational Records
- ☐ Other: _____

Purpose for the Disclosure: For Continuity of Care *Participant Initials* _____

Optional: I also agree to the disclosure of HIV Testing, Information and AIDS Diagnosis *Participant Initials* _____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided by the regulation. I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below. I also hereby release UNLEASHING POTENTIAL, LLC from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment by the individual or UNLEASHING POTENTIAL, LLC, above.

Participant/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

☐ Notice of Revocation: As of today I, _____, revoke consent from the above entity. I have revoked consent as of ____/____/____ ☐ In person ☐ By Phone ☐ In Writing

TRANSPORTATION AGREEMENT

By consenting I, _____, the parent/guardian/participant, GIVE PERMISSION for myself/my child to be transported by Unleashing Potential, LLC. I understand that staff of Unleashing Potential, LLC, will take all reasonable precautions while transporting, but cannot be held accountable for unavoidable accidents.

Parent/Guardian/Participant's Initials _____

By refusing transportation I, _____, the parent/guardian/participant, DO NOT CONSENT OR AUTHORIZE Unleashing Potential, LLC, to transport myself/my child. I am clear that any events or activities I would like myself/my child to participate in, I will be responsible for drop off and pick-up. I do understand that in the event I would like to change my mind and would like to have transportation services I will have to complete a new consent form.

Parent/Guardian/Participant's Initials _____

CONSENT FOR SERVICES

I understand the benefits of each service as well as the alternatives to the recommended procedures and/or treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from UNLEASHING POTENTIAL, LLC. I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative treatment available at UNLEASHING POTENTIAL, LLC. I may also be discharged from UNLEASHING POTENTIAL, LLC Psychiatric Rehabilitation Program if there is non-compliance with one or more of the agreed upon services.

PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

You are a partner in your mental health care and have the right to:

- Be in a safe environment and be treated with respect and dignity.
- Receive appropriate and humane treatment and services in the least restrictive setting that is consistent with your treatment needs and legal requirements.
- Know the names and titles of providers providing care and treatment.
- Refuse to participate in physically intrusive research conducted by a Provider or facility
- Ask questions and discuss your care and treatment with your doctor and provider(s) including potential risks and benefits of prescribed treatment.
- Privacy and confidentiality related to all aspects of care.
- Be protected from neglect and physical, emotional, sexual or verbal abuse.
- Participate in developing your individual treatment goals and/or service plan and all decisions made regarding your mental health care.
- Refuse treatment or medications unless ordered by the courts, or when there is an emergency, or if you are admitted to the hospital involuntarily and medication is approved by a clinical review panel.
- Refuse care and services from a Provider.
- Voice complaints and be told how to file grievances and appeals.
- See and read your medical/treatment record, unless the Provider determines it may be harmful, and then the Provider will explain this to you.

Because you are a partner in your mental health care you also have responsibilities to:

- Take charge of your recovery each day. Make Choices that help you stay healthy and meet your goals.
- Participate in activities that promote physical, emotional and spiritual health.
- Learn about your mental illness and treatment options.
- Understand benefits, risks and side effects of medication so you can make informed choices. Tell your health care provider and others if you are having side effects from medications.
- Ask for support when needed and accept support from people you trust.
- Give your therapist or doctor the information he or she needs to provide you with the best care.
- Actively participate in treatment decisions. Ask questions and offer suggestions to your therapist or doctor. Remember it is your recovery.
- Be on time for appointments. Call the office if you cannot keep an appointment.
- Eat well, exercise, and get enough rest.
- Plan ahead for psychiatric emergencies with people you trust to carry out your desires and give them a copy of your crisis plan.
- Apply for entitled benefits.
- Report suspected fraud or abuse.

CONFIDENTIALITY NOTIFICATION

The communication between you and UNLEASHING POTENTIAL, LLC is confidential. This means that we will not disclose or discuss information about you, with anyone without your express written consent. There are certain occasions in which confidentiality may be broken as governed either by legislation, government regulations and/or court orders. These include but are not limited to:

1. An emergency in which your life is in danger and which you are unable to provide information on your own.
2. If in our judgment you are a danger to yourself or others. In this case, we may be required to inform another healthcare provider, hospital, specific individual and/or a governmental/regulatory body.
3. When we are ordered to release information on your behalf by an appropriate legal authority.
4. When, in the case of an individual who has a guardian, such as a minor child, the guardian gives explicit written permission to do so.
5. When reporting is required by state-law, such as in the case of alleged child or adult abuse or neglect.

I have read the above disclosure and/or this disclosure has been explained to me. I understand and accept this arrangement of confidentiality.

NOTICE OF PRIVACY PRACTICES (HIPAA LAWS)

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE FURTHER DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PHRASE "PROTECTED HEALTH INFORMATION" REFERS TO ANY MEDICAL OR BEHAVIORAL HEALTH INFORMATION, INCLUDING DEMOGRAPHIC INFORMATION THAT CAN BE USED TO IDENTIFY YOU.

Please Review This Notice Carefully
If you have any questions about this notice, please contact our Compliance Officer

UNLEASHING POTENTIAL, LLC understands that all protected health information (PHI) about you is personal and we are committed to protecting this information. We create a record of care and services you receive at this agency to provide you with quality care and to comply with certain legal requirements. This notice applied to all records about your care generated by UNLEASHING POTENTIAL, LLC whether made by UNLEASHING POTENTIAL, LLC staff or your own personal doctors and healthcare providers. Your personal doctor and other healthcare providers may have different policies or notices regarding their use and disclosure of your medical information that is created in their offices.

This notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your protected health information.

We are required by law to:

- Make sure that protected health information that identifies you is private.
- Give you this notice of our legal duties and privacy practices with respect to the protected health information about you.
- Follow the terms of this notice that is currently in effect.

How We May Use Your Protected Health Information (PHI)

The following categories describe the different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment: We may use PHI about you to provide you with behavioral health services. We may disclose PHI about you to Case Managers, Nurses, Psychiatrists Advocates, or other UNLEASHING POTENTIAL, LLC staff members providing services within the agency. Different programs within the agency may also share PHI in order to coordinate the different services you need. For example, a case manager may share your address and telephone number with a participant advocate who will assist you with filing papers to receive SSI payments. We may also disclose PHI about you to people outside of the agency such as family members, therapists or others we use to provide services that are part of your care.

For Payment: We may use and disclose PHI about you so that the services you receive from our agency may be billed to your insurance company or third party. For example, we may need to give your health plan information about the case management services we provide so that we may receive payment from them for providing you with those services.

For Health Care Operations: We may use or disclose your PHI for agency operations. These uses and disclosures are necessary to run the agency and make sure all of our participants receive quality are. For example, we may use PHI to receive the quality service provided and to evaluate the performance of our staff caring for you. We may also disclose PHI that we have about medical information that another organization has to compare how we are doing and to see where improvements can be made to the services that we offer. We may however, remove information that identifies you so others outside of the agency cannot learn who our specific participants are.

Appointment Reminders: We may use or disclose PHI to contact you as a reminder that you have an appointment with UNLEASHING POTENTIAL, LLC staff to discuss services.

Health Related Benefits and Services: We may use or disclose PHI to tell you about health-related benefits or services that may be of interest to you.

Individuals Who Are Involved in Your Care or Payment for Your Care: We may release PHI to a friend, family member or caregiver who is involved in your behavioral or medical care. We may also give information to someone who helps us to pay for your services. We may also tell your friend, family member or caregiver your condition.

Retirement Law: We may disclose PHI about you when we are required to do so by federal, state or local law. The disclosures will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified as required by law of any such disclosures.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose PHI about you to respond to a court order or administrative order. We may also disclose PHI about you to a subpoena, discovery request or other lawful processes by someone else involved in a dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar person
- About a victim of crime if under certain limited circumstances we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct of the agency and
- In emergency circumstances to report a crime, the location of the crime, or victim or the identity, description or location of the person who committed the crime.

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if necessary, for law enforcement authorities to identify or apprehend an individual.

Abuse and Neglect: We may disclose your PHI to a public health authority by law to receive reports of child abuse and neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity/agency authorized to receive such information. In this case the disclosure will be made consistent with the requirement of applicable federal and state laws.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to that correctional institution or law enforcement official. This release would be necessary for the institution to provide you with medical or behavioral healthcare to protect your health and safety, to protect the health and safety of others or for the safety of the correctional institution.

Coroners Medical Examiners, Funeral Directors and Organ Donations: We may disclose PHI to a coroner or medical examiner for identification purposes, determining the causes of death or for the coroners and/or medical examiners to perform other duties authorized by law. We may disclose PHI to a funeral director in order for them to carry out their duties. PHI may also be used and disclosed for organ donation purposes.

Military and Veterans: When appropriate conditions apply, we may disclose the PHI of individuals who are in the Armed Forces personnel for:

- Activities deemed necessary by appropriate military command authorities
- The purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits
- To foreign military if you are a member of that foreign military service.

National Security and Intelligence Activities: We may use or disclose your PHI to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law. We may also use or disclose your PHI to authorized federal officials so that they may provide protection to the President of the United States, other authorized persons, or foreign head of state.

Emergencies: We may use or disclose PHI in an emergency situation. If this happens, a representative from UNLEASHING POTENTIAL, LLC will try to obtain your consent as soon as reasonably practical after the delivery of the emergency treatment.

Public Health Risk: We may disclose your PHI for public health services. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, abuse or neglect

- To report reactions to medications or problems with products
- To notify people of recalls or products they may be using
- To identify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Communicable Disease: We may disclose your PHI if authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include for example, audits, investigations, inspections and licensing. These activities are necessary, for the government to monitor the healthcare systems, government programs, and compliance with civil rights laws.

Food and Drug Administration: We may disclose PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products, to enable recalls, to make repairs or replacements or to conduct post marketing surveillance as required.

Communication Barriers: We may use or disclose your PHI if a representative from UNLEASHING POTENTIAL, LLC attempts to obtain consent from you but is unable to do so due to significant communication barriers and the representative from UNLEASHING POTENTIAL, LLC determines, using professional judgment that your intent to consent to use or disclose under the circumstances.

Worker's Compensation: Your PHI may be disclosed by UNLEASHING POTENTIAL, LLC as authorized to comply with worker's compensation laws and other similar legally established programs.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has received the research proposal and established protocols to ensure the privacy of your PHI.

Rights Regarding Your PHI: The following is a statement of your rights with respect to your protected health information (PHI) and a brief description of how you may exercise these rights.

You Have a Right to Inspect and Copy Your PHI: This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. Usually these records include any medical, behavior health or billing records that the agency uses for making decisions about your services. These records do not include psychotherapy notes.

To inspect and copy PHI, you must submit your request in writing to UNLEASHING POTENTIAL, LLC. Administrator/Program Director. If you request a copy of the information, we may charge you a few for the cost of copying, mailing or other supplies associative with your request.

We may deny your request to inspect and copy in very limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. Please contact the Administrator/Program Director if you have any questions about access to your record.

You Have the Right to Ask Us to Amend Your PHI: If you know that the PHI we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by UNLEASHING POTENTIAL, LLC.

To request an amendment, your request must be in writing and submitted to UNLEASHING POTENTIAL, LLC. Administrator/Program Director. In addition, you must provide a reason that supports your request.

We may deny a request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UNLEASHING POTENTIAL, LLC unless the person or entity that created the information is no longer available to make the amendment.
- Is not a part of the PHI kept by or for UNLEASHING POTENTIAL, LLC;
- Is not a part of the information which you should be permitted to inspect and copy
- Is accurate and complete.

If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your amendment and will provide you with a copy of that rebuttal.

You Have a Right to Receive an Accounting of Certain Disclosures we have Made of Your PHI: This right applies to the disclosures for purposes other than treatment, payment or operations as described previously in the Notice of Privacy Practices. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You Have a Right to Request a Restriction of Your PHI: This means that you may ask us not to use or disclose any of your PHI for the purpose of treatment, payment, or operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

UNLEASHING POTENTIAL, LLC is not required to agree to a restriction that you may request. If we believe it is in your interest to permit use and disclosure of your PHI, your PHI will not be restricted. If UNLEASHING POTENTIAL, LLC agrees to this restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting UNLEASHING POTENTIAL, LLC Program Administrator/Director. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both to whom you want the limits to apply (for example disclosures to your spouse).

You Have a Right to Obtain a Paper Copy of This Notice from us. You have the right to obtain a paper copy of this notice. You may ask us to give you a copy of this notice any time. Even if you have agreed to this notice electronically, you are still entitled a paper copy of this notice.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency. This notice will contain the effective date of any changes or revisions, on the first page.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the secretary of the Department of Health and Human Services. Please contact the Program Administrator/Director for UNLEASHING POTENTIAL, LLC at 301.362.0090 or mail your complaint to: 14435 Cherry Lane Court, Suite 300, Laurel, Maryland 20707.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

LIABILITY WAIVER NOTICE

I, _____hereby agree to release and hold harmless from any liability, UNLEASHING POTENTIAL, LLC including its paid and volunteer staff executors, administrators and other agents representing UNLEASHING POTENTIAL, LLC. This waiver specifically relates to personal injury which may occur while participating in any programs or activity of any kind conducted, approved, organized, or sponsored by UNLEASHING POTENTIAL, LLC or its representatives.

Further, that the consideration for this waiver, is the right, privilege and opportunity for myself/my child to participate in the programs and activities conducted, approved, organized or sponsored by UNLEASHING POTENTIAL, LLC.

PHOTOGRAPH/MEDIA CONSENT AND RELEASE

If I choose to consent and authorize UNLEASHING POTENTIAL, LLC to take photographs or motion pictures of myself (and/or my child); or to produce videotapes, audiotapes, closed circuit television programs, web casts, or other types of media productions that capture myself (and/or my child's), voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

I, _____, authorize UNLEASHING POTENTIAL, LLC to copyright the materials, and I authorize UNLEASHING POTENTIAL, LLC to use, reuse, copy, publish, display, exhibit, reproduce, license to third party, and distribute the materials in any educational or promotional materials or other forms of media, which may include, but are not limited to university publications, catalogs, articles, magazines, recruiting brochures, websites or publications, electronic or otherwise, without notifying me. I agree to these items to be used up to 99 years after the initial date of use. I agree that I am participating on a voluntary basis and I will not receive any payment from UNLEASHING POTENTIAL, LLC for signing this release or as a result of any publication of the materials.

If I choose be photographed or recorded, I do not consent or authorize UNLEASHING POTENTIAL, LLC to take photographs or motion pictures of myself (and/or my child); or to produce videotapes, audiotapes, closed circuit television programs, web casts, or other types of media productions that capture myself (and/or my child's), voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

MEDICATION LOG

NAME: _____ MA#: _____

DATE	DRUG/DOSAGE	FREQUENCY	CONCERNS

_____ _____

Reviewed By: Date:

PARTICIPANT CRISIS PLAN

(Participant Copy)

You may never need to use a crisis hotline or a mobile crisis team. Preparing for a crisis does not mean that one will occur. However, it is wise to prepare for a crisis ahead of time, so you have the support and plan in the event you need them. You have access to several resources to help you prevent and prepare for a crisis.

Any of the names listed below can be contacted in a crisis:

- UNLEASHING POTENTIAL, LLC 410-701-7552
- Mental Health Provider (Clinician) _____
- PRP Counselor _____
- Primary Care Physician _____
- Emergency Contact _____
- Suicide Prevention Hotline 1-800-273-8255
- Maryland Suicide Hotline 410-752-2272
- Maryland Youth Crisis Hotline 1-800-442-0009

_____ _____

_____ _____

_____ _____

PARTICIPANT CRISIS PLAN
(Clinic Copy)

Participant Name: _____ Date: _____

Address: _____

Parent/Guardian: _____ Contact: _____

You may never need to use a crisis hotline or a mobile crisis team. Preparing for a crisis does not mean that one will occur. However, it is wise to prepare for a crisis ahead of time so you have the support and plan if you even needed them. You have access to a number of resources to help you prevent and prepare for a crisis.

Any of the names listed below can be contacted in a crisis:

- UNLEASHING POTENTIAL, LLC 410-701-7551
- Mental Health Provider (Clinician) _____
- PRP Counselor _____
- Primary Care Physician _____
- Emergency Contact _____
- Suicide Prevention Hotline 1-800-273-8255
- Maryland Suicide Hotline 410-752-2272
- Maryland Youth Crisis Hotline 1-800-442-0009

_____ _____

_____ _____

_____ _____

CONSENTS AND ACKNOWLEDGEMENT

Participant Name: _____

Guardian Name (if applicable): _____

Consent for Services: ☐ PRP *(Blended)* ☐ PRP *(On-Site Only)* ☐ PRP: *(Off-Site Only)*

☐ Substance Use Disorder Program ☐ Outpatient Mental Health Clinic

Consent for Transportation: ☐ Transport ☐ Do Not Transport

Consent for Photography/Video: ☐ I Do Consent ☐ I Do Not consent

Mental Health Advance Directives: ☐ I currently have one and do not need to update it at this time.

(16 and over) ☐ I have received a copy and will return it at a later time.

☐ I have received a copy, completed it and returned it to staff.

☐ I am refusing to sign one at this time.

Participant Handbook: ☐ I have received a copy electronically at this email address:

_____

☐ I have received a paper copy

My signature below is acknowledgement that the following information was reviewed and explained to me during the intake process:

_____ Privacy (HIPAA) Laws
_____ Participant Rights as Participants in UNLEASHING POTENTIAL, LLC programs
_____ Grievance Procedure (Handbook)
_____ Procedure for Discharge (Handbook)
_____ Confidentiality of Records and Release of Information
_____ Description of Services Offered by UNLEASHING POTENTIAL, LLC
_____ Liability Waiver Notice
_____ Reviewed Participant Handbook

As a participant or designee of the participant, my signature below indicates that I understand the information above and that I agree to adhere to the policy, protocol and/or procedures to each of the items listed as they relate to me at any given time as a participant in UNLEASHING POTENTIAL, LLC programs.

_____ _____

Signature Date