



Consent to Participate in Services



IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

DATE

TREATMENT AND PARTICIPATION

I/ my ward/ my child agrees to participate in the services/treatment offered by LifeWays. The services may be provided by LifeWays or LifeWays' provider network. I understand that I will be asked to consent to a treatment plan based on my needs. My treatment plan (we also call this an Individual Plan of Service) will be written by my treatment team, and, if I want, will include input from my family, and/or other support professionals who take part in my care.

I understand that additional consents may be necessary for certain treatment options such as psychotropic medications

I understand that all services/treatments will be explained to my satisfaction including their purpose, risks, benefits, and any appropriate alternatives.

RECEIPT

The following items have been explained to me and I have received a copy of the following:

- Welcome to LifeWays Letter
- Your Rights Booklet
- LifeWays Guide To Services
- LifeWays Notice of Privacy Practices
- Information on Grievances, Appeals, and Second Opinions
- Michigan Advance Directive for Mental Health Care Brochure
- 2-1-1 Brochure
- LifeWays Community Mental Health Services Brochure
- Consumer Responsibilities

NOTIFICATION

I understand that LifeWays or LifeWays' Provider Network are required to coordinate my treatment with medical providers who care for my physical health, specifically my primary care provider.

I understand that when a LifeWays or LifeWays' Provider Network employee/provider has been accidentally exposed to my blood and/ or bodily fluids my/ my ward's/ my child's blood may be tested for Hepatitis B and HIV (Aids Virus). I will be told of any positive results unless I/ my ward/ my child cannot be found when the results are received. (in accordance with Michigan Law; PA 488 and LifeWays policy)

I understand that LifeWays or LifeWays' Provider Network is authorized to release non-identifying information on any reportable communicable disease, infection, and/or condition to the Michigan Department of Health and Human Services in accordance with the Michigan Mental Health Code Public Act 258 of 1974, Section 748, Rule 330.1748 Confidentiality.

FOLLOW-UP



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I understand LifeWays or LifeWays' Provider Network may contact me for purposes of obtaining follow up information concerning my satisfaction and progress since receiving services. This information is used internally for quality improvement purposes and to determine if services have been effective. All information is protected by LifeWays or LifeWays' Provider Network and its representatives to ensure confidentiality.

VALID

I understand that I may withdraw my consent and participation at any time without penalty.

I understand that I may revoke at any time except to the extent that action has been taken in reliance on it.

This consent shall no longer be valid one year from the date of this form. Any forms signed after the date on this form shall replace this form and be considered the most current consent.

Upon request, I may receive a copy of this consent

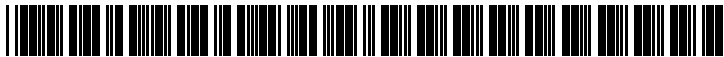
SIGNATURES

My signature acknowledges my understanding that I am agreeing to participate in services at LifeWays and/or one of LifeWays network provider agencies.

**SIGNATURES**

\_\_\_\_\_  
STAFF SIGNATURE / CREDENTIALS DATE

\_\_\_\_\_  
CONSUMER / PARENT / GUARDIAN SIGNATURE PRINTED NAME DATE



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Note: A new consent form must be obtained if: legally competent minor reaches his/her 18th birthday; or c) change of guardianship status.

\*Witness is responsible to, in good faith, assure that if the consumer signs, she/he was competent to give informed consent (R330.7003) (R300.6013) (a)-(c) Michigan Department of Community Health emergency rules, or if guardian signed, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel the consumer is competent, refer to R330.6011 (3)-(4)

Testing for HBV/HIV without consent would not be for routine testing, rather for testing after unexpected staff contact with bodily fluid. 333.5133.10b "The HIV test is performed after a health professional, health facility employee, police officer, or fire fighter, or a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic licensed under section 20950 or 20952 sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the blood or other body fluids of the patient."



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## Recovery Technology Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and

conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As social workers licensed in this state and as members of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.** PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Recipients Rights Officer.

**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

## COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Recipient Rights Officer at (517) 796-4520

**We will not retaliate against you for filing a complaint.**



Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_

## Therapy Participation Agreement

Psychotherapy can be an effective treatment for a variety of mental health conditions and concerns. It can assist you in developing new coping skills that will empower you to overcome the stressors and symptoms that prevent you from enjoying life to its fullest.

Effective therapy however, is different than a doctor's appointment. Effective therapy depends greatly on your active participation in the therapeutic process and development of a strong therapeutic relationship with your therapist. For this reason, it is imperative to attend and participate in therapy sessions on a regular basis.

At Recovery Technology we ask that you miss no more than 2 appointments per any 3 month period that you are in services with us. **Missing any more than 2 appointments within 3 months will result in discharge from services.** We understand that at times unforeseen circumstances may prevent you from participating in your scheduled sessions. If you are unable to keep an appointment with your therapist we request that you cancel no later than 24 hours prior to the scheduled appointment. **If you do not cancel prior to 24 hours, your absence will be considered a missed appointment.**

If you are discharged from therapy services due to missed appointments or due to not responding to our attempts to reach you after a missed appointment, **you will not be able to return to therapy services at Recovery Technology until a period of at least one year past the date you are discharged.** If you wish to return to therapy services after one year has passed, your return may be considered but it is not guaranteed and may require negotiation.

By signing below, I acknowledge that I understand and agree to the above attendance conditions.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_





## Tele-mental Health Informed Consent

I, \_\_\_\_\_, hereby consent to participate in tele-mental health with, \_\_\_\_\_, as part of my treatment. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care required.
- 6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at \_\_\_\_\_ to discuss since we may have to reschedule.
- 7) I understand that my clinician/staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone: \_\_\_\_\_  
\_\_\_\_\_

I have read the information provided above and discussed it with my clinician/staff. I understand the information contained in this form and all my questions have been answered to my satisfaction.

\_\_\_\_\_  
Signature of client/parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of clinician/staff

\_\_\_\_\_  
Date:



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## Notice of Privacy Practices

### *Receipt and Acknowledgment of Notice*

Client Name \_\_\_\_\_ Case # \_\_\_\_\_ Date \_\_\_\_\_

DOB: \_\_\_\_\_

**I hereby acknowledge that I have received and have been given an opportunity to read a copy of Recovery Technology's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Recipient Rights Officer Andra Antczak at (517) 796-4520.**

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

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Client/Patient Refuses to Acknowledge Receipt

Signature of Staff Person: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent to Share Behavioral Health Information

**Use this form to give or take away your consent to share information about your:**

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout the form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

**Why This Form is Needed**

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

**Instructions**

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

**SECTION 1: ABOUT YOU**

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	DATE SIGNED

**SECTION 2: WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT**

**SECTION 2A: SHARING INFORMATION BETWEEN INDIVIDUALS AND ORGANIZATIONS**

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

**SECTION 2B: SHARING INFORMATION ELECTRONICALLY**

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

CHOOSE ONLY ONE OPTION:

- Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a
- Do not share my information through the organizations listed below.
- Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.
- PCE Systems
- Michigan Health Information Network

**SECTION 3: WHAT INFORMATION YOU WANT TO SHARE**

CHOOSE ONE OPTION:

- Share **all** of my behavioral health and substance use disorder records. This does not include "psychotherapy notes."
- Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____

**SECTION 4: YOUR CONSENT AND SIGNATURE**

Read the statements below, then sign and date the form.

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.
- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it after the event or condition listed below. (For example, at the end of my treatment.)

Date, event, or condition:

CONSUMER SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE	PRINTED NAME	DATE
WITNESS SIGNATURE	PRINTED NAME	DATE

**TAKE AWAY YOUR CONSENT**

Complete Section 5 if you no longer want to share your records listed above in Section 3.

SECTION 5: WHO CAN NO LONGER SEE YOUR INFORMATION	
<p>I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.</p> <p>State your relationship to the person withdrawing consent, then sign and date below.</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Parent (Print Name)</p> <p><input type="checkbox"/> Guardian (Print Name)</p> <p><input type="checkbox"/> Authorized Representative (Print Name)</p>	
<p>_____ SIGNATURE</p>	<p>_____ DATE</p>
<p>_____ WITNESS SIGNATURE (IF APPROPRIATE)</p>	<p>_____ DATE</p>

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY	
VERBAL WITHDRAW OF CONSENT	
<p><input type="checkbox"/> The individual listed above in Section 1 has taken away his/her consent.</p> <p>List the individual who requested the withdrawal below, then sign and date below.</p> <p><input type="checkbox"/> Individual listed in Section 1</p> <p><input type="checkbox"/> Parent (Print Name)</p> <p><input type="checkbox"/> Guardian (Print Name)</p> <p><input type="checkbox"/> Authorized Representative (Print Name)</p>	
<p>_____ SIGNATURE OF PERSON RECEIVING VERBAL WITHDRAW OF CONSENT</p>	<p>_____ DATE</p>

**Other Information for Health Care Providers and Health Plans**

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at [michigan.gov/bhconsent](http://michigan.gov/bhconsent)

Additional Identifiers (Optional)		
MEDICAID	LAST 4 OF THE SOCIAL SECURITY NUMBER	CASE #

Form Copy (Optional, Choose One Option)
<p><input type="checkbox"/> The individual in Section 1 <b>received</b> a copy of this form.</p> <p><input type="checkbox"/> The individual in Section 1 <b>declined</b> a copy of this form.</p>

<b>AUTHORITY:</b>	This form is acceptable to the Michigan Department of Health and Human Services (MDHHS) as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.
<b>COMPLETION:</b>	Is Voluntary, but required if disclosure is requested.
<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>	



# AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

COGNITIVE PATIENT  
LABEL

Questions: Contact Medical Records: 313.916.4540

Please mail completed form to: Medical Records 1414 E. Maple Road, Troy, MI 48083 (**Mailing Address ONLY**)  
or Medical Records email address: HFHSMedicalRecords@hfhs.org • fax number 313.916.3917  
(Please keep in mind that emails sent over the internet may not be secure.)

### Patient Information (please print)

Name (First, Middle, Last)		Maiden name or previous names	
Address	City	State	Zip Code
Date of Birth	Phone	E-mail Address if Applicable	

### I authorize my records to be sent from:

#### Henry Ford Health:

- |  |  |
|--|--|
| <input type="checkbox"/> HF Jackson                    | <input type="checkbox"/> HF Macomb Hospital                      |
| <input type="checkbox"/> HF Jackson Specialty Hospital | <input type="checkbox"/> HF Maplegrove Center                    |
| <input type="checkbox"/> HF Behavioral Health          | <input type="checkbox"/> HF West Bloomfield Hospital             |
| <input type="checkbox"/> HF Hospital Detroit           | <input type="checkbox"/> HF Wyandotte Hospital                   |
| <input type="checkbox"/> HF Kingswood Hospital         | <input type="checkbox"/> HF Other (Clinic/Medical Center): _____ |

#### Other Facility:

Name/Organization			
Address	City	State	Zip Code

### I authorize my records to be released to:

#### Myself: (Select only one option)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> MyChart patient portal<br>(patient request)  | <input type="checkbox"/> E-mail to me at address above | <input type="checkbox"/> Mailed to me at address above |
| <input type="checkbox"/> On site inspection. (Authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.) |  |  |
| <input type="checkbox"/> Mailed to address below  | <input type="checkbox"/> Faxed to number below         |  |

#### Other: Disclose to - complete information below

Name/Organization Recovery Technology			
Address 1200 N. West Ave, Suite 400	City Jackson	State MI	Zip Code 49202
Phone Number 517-780-3336	Fax Number 517-796-4561		

**Please complete below if you want to include medical records for these services:**

- Substance Use Disorder diagnosis and treatment  
 Purpose:  Continuation of Care  Legal  Personal  Other \_\_\_\_\_
- Psychotherapy Notes

**Specific Information Requested:**

Type of Record requested	Date of Service	Type of Record Requested	Date of Service
<input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Outpatient Record	
<input type="checkbox"/> Emergency Department		<input type="checkbox"/> Radiology Report	
<input type="checkbox"/> Laboratory Report		<input type="checkbox"/> Office Note	
<input type="checkbox"/> Immunizations		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Inpatient Record			

By signing this authorization, I hereby authorize Henry Ford Health System to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on: general medical care, psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), as applicable; communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable; demographic information; and treatment received by other health care providers. Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

**I understand that:**

- I may revoke (take back) this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released prior to receiving the revocation. Contact Henry Ford Health System Medical Records department. Contact information is available at the top of the form.
- This authorization expires when the patient information is disclosed as permitted in this authorization, or within one (1) year from the date that it is signed unless another expiration date is written here: \_\_\_\_\_ (describe the date/event/condition upon which authorization will expire, which must be no longer than one year from the date signed)
- My care or treatment will not be conditioned on signing this authorization
- The person(s) to whom information is disclosed under this authorization may possibly redisclose the information to others without the patient’s knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
- Henry Ford Health System and/or its copying service reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature \_\_\_\_\_ Relationship (if other than patient) \_\_\_\_\_

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA. (if legal guardian, Personal Presentative or person of authority under a durable medical power of attorney, a copy of appropriate documentation may be required)

Date \_\_\_\_\_ Time \_\_\_\_\_





**Authorization to Exchange Information  
between LifeWays CMH and MDHHS  
(Michigan Department of Health and Human Services)**

Instructions on completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) form:

1. All areas should be complete
2. This form must be signed and dated by the patient or guardian.
3. This form can be faxed to 517-796-4532 or returned to the LifeWays Network Benefits Team

<b>Patient First Name:</b>	<b>Patient Last Name:</b>	<b>Date of Birth:</b>		
<b>Patient Address (street, city, zip):</b>				
<b>Guardian Name:</b> Check if Not Applicable <input type="checkbox"/>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; padding: 5px; vertical-align: top;">           This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated:   <b>Alternative Expiration Date:</b> </td> <td style="width: 55%; padding: 5px; vertical-align: top;">           Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from:             Michigan Department of Health and Human Services         </td> </tr> </table>			This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated:  <b>Alternative Expiration Date:</b>	Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from:  Michigan Department of Health and Human Services
This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated:  <b>Alternative Expiration Date:</b>	Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from:  Michigan Department of Health and Human Services			
<p>I, or my guardian, request that information regarding federal/state program benefit determination and contact information including- but not limited to- first name, last name, phone number, and address be exchanged to LifeWays Community Mental Health for purpose of any state/federal benefits (cash, food, Medical).</p>				
<p><b>I understand that:</b></p> <ol style="list-style-type: none"> <li>1. Protected health information may include information and records protected under federal and state law such as benefit determination and first name, last name, phone number, and address.</li> <li>2. My treatment, payment or eligibility of benefits may not be conditioned on signing this authorization.</li> <li>3. I understand that I may revoke this authorization at any time by writing to LifeWays, Attn: Customer Services, 1200 N. West Ave. Jackson, MI 49202, except to the extent that LifeWays has taken action in reliance to the authorization.</li> <li>4. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.</li> </ol>				
<hr style="border: 0; border-top: 1px solid black;"/> <b>Signature of Claimant/Consumer, Guardian or Authorized Representative</b>		<hr style="border: 0; border-top: 1px solid black;"/> <b>Date</b>		
<hr style="border: 0; border-top: 1px solid black;"/> <b>Printed Name of Claimant/Consumer, Guardian or Authorized Representative</b>		<hr style="border: 0; border-top: 1px solid black;"/> <b>Date</b>		



**Choice of Provider**

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Case # \_\_\_\_\_

Outpatient Therapy: \_\_\_\_\_  Not Applicable

Case Management: \_\_\_\_\_  Not Applicable

Assertive Community Treatment: \_\_\_\_\_  Not Applicable

Outpatient Psychiatric Services: \_\_\_\_\_  Not Applicable

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Other: \_\_\_\_\_

I attest that I have been given a choice of provider for services.

\_\_\_\_\_  
Client/Guardian

Date: \_\_\_\_\_



## Primary Physician Coordination of Care Form

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Re: \_\_\_\_\_

DOB \_\_\_\_\_

Dear Dr. \_\_\_\_\_

**This is to inform you that the above-named patient has had the following change in treatment:**

Hospitalization

Crisis Home Placement

Other: \_\_\_\_\_

**Receiving the following services:**

Outpatient Mental Health Therapy

Substance Abuse Therapy

Assertive Community Treatment

Integrated Dual Disorder Treatment

Dialectical Behavior Therapy

Case Management

**Request information from you:**

Most current lab results

Diagnosis that you are treating

Most recent physical exam results

Immunization Records

Medications being prescribed by you

Other: \_\_\_\_\_

**The Patient's Diagnosis is:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The patient has signed a release allowing further contact between us. Please feel free to contact me for any questions or coordination of care.

Clinician: \_\_\_\_\_  
(please print)

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Clinician Signature/Credential



## Service Orientation Checklist

Client Name: \_\_\_\_\_

Case #: \_\_\_\_\_

**Please check all that apply:**

I have chosen the following service(s):

Individual Therapy

Assertive Community Treatment

Case Management

Integrated Dual Diagnosis Treatment

Anger Management

Psychiatric

Dialectical Behavior Therapy

Other

I have been educated on the service I have chosen and had a chance to ask questions.

I have been informed that the Internal Recipient Rights Advisor for Recovery Technology is Andra Antczak at 796-4520.

I was trained on the emergency preparedness plan (fire, tornados, bomb threats, assaults with weapons, aggressive behaviors and how to use the fire extinguishers and emergency exits.)

Self-determination was explained to me and I was given the choice to participate or not.

Quality Improvement was explained to me and I was invited to be a member of the Advisory Board Committee (ABC).

Clinician discussed with me the importance of keeping appointments and participating in services scheduled. **I understand that if I miss 3 appointments I may be discharged from the service.**

Treatment is court ordered and the requirements for follow-up and discharge have been explained to me.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date



## Informal Complaint Process

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Case #: \_\_\_\_\_

If you have any questions or concerns regarding your services at Recovery Technology, please call one of the following phone numbers for assistance. If you are unhappy with the outcome of your informal complaint, please contact a member of Recover Technology’s management team or if referred by LifeWays, you may contact LifeWays Customer Service.

### For Recovery Technology:

Clinician’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Recovery Technology Receptionist 517-780-3336

Recovery Technology CEO/Management 517-780-3336

Recovery Technology Recipient Rights Advisor 517-796-4520

### If referred by LifeWays:

LifeWays Customer Service 517-780-3332

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Communication and Message Consent Form

Client Name: \_\_\_\_\_ Case #: \_\_\_\_\_ Date: \_\_\_\_\_

We, at RECOVERY TECHNOLOGY LLC, are committed to safeguarding the privacy and confidentiality of your records including the personal information that you provide us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time, it may be necessary or desirable to contact patients by phone **or text**. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

- I **DO NOT** want to have detailed messages left with another person who could answer my phone.
- I **DO NOT** want to have detailed messages left on my voicemail.
- I **DO NOT** want to be texted with appointment reminders.
- I **DO NOT** want to receive phone calls with appointment reminders.
- I **DO NOT** want to receive phone calls at my place of employment.

### TEXT MESSAGING INFORMATION

**How we will use text messaging:** We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your text messages may be forwarded to another RECOVERY TECHNOLOGY LLC staff member as necessary for appropriate handling. We will not disclose your text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

**Risk of using text messages:** The use of text messages has a few risks that you should consider. These risks include, but are not limited to, the following:

- Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress a text and send the information to an undesired recipient.
- Employers and on-line services have a right to inspect texts sent through their company systems.
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

### Conditions for the use of text messages:

RECOVERY TECHNOLOGY, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions (by signing below):

- **IN A MEDICAL EMERGENCY, DO NOT USE TEXTING, CALL 911.**
- If you have an urgent problem during regular business hours, please call your case manager or outpatient therapist, or 517-780-3336. Urgent messages or needs should be relayed to us by using regular telephone communication.
- You should speak with your case manager or therapist to discuss complex and/or sensitive situations rather than using text messages regarding such situations.

- Text messages may be filed electronically into your medical record.
- Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of text messages for communication of sensitive medical information. **Clinical staff are not responsible for the content of messages.**
- RECOVERY TECHNOLOGY, LLC is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with staff if warranted.

**I UNDERSTAND THAT STANDARD CELL PHONE RATES AND TEXT MESSAGING RATES WILL APPLY TO ANY MESSAGE RECEIVED FROM RECOVERY TECHNOLOGY. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. MY REVOCATION OF CONSENT WILL NOT AFFECT MY ABILITY TO OBTAIN FUTURE HEALTH CARE NOR WILL IT CAUSE THE LOSS OF ANY BENEFITS TO WHICH I AM OTHERWISE ENTITLED.**

***THIS CONSENT DOES NOT EXPIRE UNLESS SPECIFICALLY REVOKED BY THE CLIENT/GUARDIAN.***

Client/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date \_\_\_\_\_

LIFEWAYS CRISIS PLAN

Client Name:  
Client Case #:

**CONSUMER CHOOSES TO PARTICIPATE IN CRISIS PLANNING**

YES      NO      IF NO, EXPLAIN WHY \_\_\_\_\_

**HOW DO YOU KNOW WHEN I AM IN CRISIS?**

---

---

---

**DON'T DO (BLANK) WHEN I AM IN CRISIS:**

---

---

---

**DON'T TAKE ME TO OR TAKE ME TO (NOTE BOTH AND WHY):**

---

---

---

**SYMPTOMS, FEELINGS OR TRIGGERS THAT MAY LEAD TO A CRISIS:**

WANTING TO HURT MYSELF OR SUICIDAL. WHY/HOW? \_\_\_\_\_

---

WANTING TO HURT OTHERS. WHY/HOW? \_\_\_\_\_

---

ATTEMPTING SUICIDE. HOW? \_\_\_\_\_

---

FEELING NOT HEARD. HOW? \_\_\_\_\_

---

BULLYING. HOW? \_\_\_\_\_

---

USING DRUGS/ALCOHOL TO COPE. WHY? \_\_\_\_\_

---

LOSING TEMPER                      FIGHTING WITH OTHER PEOPLE                      USING DRUGS OR ALCOHOL

INCREASE OR DECREASE IN SLEEP                      NOT EATING FOR SEVERAL DAYS                      HEARING VOICES

GAMBLING LOSS. WHAT TYPE? \_\_\_\_\_

---

BEING TOUCHED. WHY? \_\_\_\_\_

---

CRYING NON-STOP OR OFF/ON. WHY? \_\_\_\_\_

---



NOT PAYING MY BILLS                              BECOMING PHYSICALLY ILL                              FEELING UNSAFE  
 POTENTIAL LOSS OF HOUSING                              CHANGE IN HYGIENE                              NOT KEEPING APPOINTMENTS  
 POTENTIAL LOSS OF CHILDREN/FAMILY. HOW/WHEN? \_\_\_\_\_

ARGUMENTS. WHAT TYPE? \_\_\_\_\_

SEEING A PARTICULAR PERSON. WHY? \_\_\_\_\_

LOUD NOISES                              LACK OF PRIVACY                              BEING RUDE  
 TIME OF YEAR                              TIME OF DAY                              OTHER: \_\_\_\_\_

**IMMEDIATE RISK CONCERNS**

ACCESS TO WEAPONS YES      NO	TYPE OF WEAPONS	CURRENT LOCATION OF WEAPONS	RISK OF HARM PRESENT YES      NO
ACCESS TO MEDICATIONS/ILLEGAL DRUGS YES      NO	MEDICATIONS THAT ARE ACCESSIBLE	CURRENT LOCATION OF MEDICATIONS	RISK OF HARM PRESENT YES      NO
PLAN TO ADDRESS IF CURRENT RISK PRESENT			

**SUPPORT SYSTEM THAT CAN HELP BEFORE OR DURING A CRISIS**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ CONTACT INFORMATION: \_\_\_\_\_ RELEASE OBTAINED  
 \_\_\_\_\_ YES      NO

**PROFESSIONAL RESOURCES THAT CAN HELP**

PRIMARY CASE HOLDER	PHONE NUMBER
LIFEWAYS CRISIS-JACKSON	(800) 284-8288; 517-789-1200
LIFEWAYS CRISIS-HILLSDALE	(800)284-8288; 517-439-2641
LIFEWAYS CRISIS R&R – JACKSON – 1200 N. WEST AVE. JACKSON, 49201	LIFEWAYS BUSINESS HOURS

**STEPS TO TAKE TO MINIMIZE OR PREVENT MY CRISIS**

TALKING WITH MY FAMILY	TALKING WITH MY THERAPIST	TALKING WITH FRIENDS
TIME OUT IN MY ROOM	USE THERAPY/DBT SKILLS	BE AROUND OTHERS
WRAP UP IN A BLANKET	TALKING WITH AN ADULT	BE NEAR MY FAMILY
PUNCH A PILLOW	TALK WITH STAFF ABOUT MY NEEDS	GO TO THE DROP-IN CENTER/SOCIAL PLACE
LIE DOWN WITH A COLD FACE CLOTH	SITTING WITH STAFF	USE A MALE OR FEMALE STAFF AS SUPPORT
TAKE A SHOWER/BATH	WATCH TV	READ (BOOK/PAPER/MAGAZINE)
DO DEEP BREATHING EXERCISE	LISTENING TO MUSIC	WRITE IN A JOURNAL
DRINK A CUP OF WARM TEA	GO FOR A WALK	START ARTWORK
HUGGING A STUFFED ANIMAL	PACE BACK/FORTH	PLAY VIDEO GAMES
GET A HUG	EXERCISE	BOUNCE A BALL
DO CHORES/JOB	COLORING IN A BOOK/PAPER	MOLDING CLAY
OTHER	DRAW ON MY AREM WITH A RED MARKER	SNAP A RUBBER BAND ON MY WRIST
OTHER		

**Did you receive a copy of your Individualized Plan of Service?** Case # \_\_\_\_\_

Yes, I received a copy. Date Received: \_\_\_\_\_  
 No, I **do not** want a copy. \_\_\_\_\_  
(initial please)

---

**Did you receive a copy of your Notice of Hearing Rights?**

Yes, I received a copy. Date Received: \_\_\_\_\_

**Signatures**

*The signatures below indicate knowledge and agreement with goals, interventions, services, strategies, outcomes, frequency, and responsible person designated in this plan. This plan will be reviewed at least quarterly.*

\_\_\_\_\_  
STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
CONSUMER SIGNATURE PRINTED NAME DATE

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE PRINTED NAME DATE

\_\_\_\_\_  
STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
ACT PSYCHIATRIST SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
RESIDENTIAL PROVIDER SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

\_\_\_\_\_  
OTHER STAFF SIGNATURE/CREDENTIALS DATE

Client Name: \_\_\_\_\_

Case #: \_\_\_\_\_

**REMEMBER TO  
COMPLETE  
DLA-20**

Client: \_\_\_\_\_

Case #: \_\_\_\_\_

**UPDATE  
FINANCIAL DETERMINATION  
FORM  
IN LEO**



1200 N. West Avenue, Suite 400  
 Jackson, MI 49202  
 (517)-780-3336/FAX (517) 796-4561

## Business Satisfaction Survey

Date: \_\_\_\_\_

Please specify how you are associated with Recovery Technology: \_\_\_\_\_

We would like your opinion on how well Recovery Technology is doing in meeting your needs and expectations. Your completed survey can be faxed to the **Attention of Jim DeBruler at 517-796-4561**. All provided information remains confidential. Please check the appropriate response. Thank you for your time and input.

**5=Excellent    4=Good    3=Average    2=Below Average    1=Unsatisfactory**

	5	4	3	2	1
1. Overall, how satisfied are you with the timeliness in which Recovery Technology responds to you and/or your organization?					
2. How would you rate the services provided by Recovery Technology?					
3. How well do you think Recovery Technology adheres to Person Center Planning?					
4. How hospitable and helpful is the Recovery Technology staff?					
5. Overall, how convenient are Recovery Technology's business of hours?					

	Yes	No	Comment
6. Would you recommend Recovery Technology to a friend?			
7. If your answer to the above question is no, would you like additional information? If so, please provide your contact information.			
8. Are you aware of all the services Recovery Technology has to offer?			
9. Did you know that your input about Recovery Technology is welcomed at any time?			
10. Do you know who you can contact if you are dissatisfied?			

11. In what ways do you think Recovery Technology can improve?

12. Additional Comments:

## Client Satisfaction Survey

Date: \_\_\_\_\_

Please specify how you are associated with RECOVERY TECHNOLOGY:

Client  Guardian  Service Provider  Other: \_\_\_\_\_

Please specify what services are being rated:

CSM/Support Coordination  Outpatient Therapy  ACT/IDDT

Physician Services  Anger Management/BIP

RECOVERY TECHNOLOGY would like to thank you for giving us the opportunity to serve you. Please help us serve you better by taking a couple minutes to tell us about the services that you have received so far. We appreciate your loyalty and want to make sure we meet your expectations. Your completed survey can be returned to our office at the address listed above. All information provided remains confidential. Please check the appropriate response. Thank you for your time and input.

If you do not have an answer or are unsure on any statement, please select "Neutral." Thank you.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Neutral
1. I like the services that I receive(d).					
2. I was able to get the services I thought I needed.					
3. Staff helped me obtain the information I needed so that I could take charge of managing my mental health or disability.					
4. I, not staff, decided my treatment goals.					
5. Staff believed that I could grow, change and recover.					
6. Recovery Technology staff is friendly and helpful.					
7. As a direct result of the services I received, I am better able to take care of my needs.					
8. Recovery Technology's staff were sensitive to my cultural/ethnic background (ex., race, religion, language, etc.).					
9. Recovery Technology staff explained my rights to me in a clear and understandable way.					
10. The services Recovery Technology deliver assisted you in managing your life/illness?					

In what ways, do you think Recovery Technology can improve? (Please continue on the back if more space is needed.)