University of Vermont Health

Primary Care Mental Health Integration
PARTICIPANT INFORMED CONSENT

Name:
DOB: MRN:

1. I have chosen to seek evaluation and treatment at UVM Health Network. My choice has been voluntary and I understand that I may terminate treatment at any time.
2. I understand that in the interest of providing the best quality of care for me, my clinician(s) may periodically seek consultation with professional colleagues who practice the same discipline.
3. I understand that during these consultations, my clinicians may identify me by name. I understand that these consultants with whom my clinician discusses my treatment are bound by laws of confidentiality not to disclose information about me and my treatment.
4. I understand that my clinician(s) will record my visit in my clinical records. The information entered will include the date(s) of my visit(s), the time spent, the diagnosis and any information that is deemed clinically important.
5. I understand that I have a right to discuss with my clinician(s) what information goes into my medical record and that my clinician must document information to reflect the services rendered and enable continuity of care.
6. I understand that my records will be released only in accordance with state and federal laws requiring confidentiality of such records.
7. I understand that there may be circumstances in which the law requires my clinician to disclose confidential information.

These circumstances include:

A) Abuse or neglect of minors or the elderly.
B) Situations in which there exists a danger to me or others.

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Patient Signature Date/Time

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Clinician Signature Date/Time