NATIONAL ALLIANCE ON MENTAL ILLNESS
NAMI, EL DORADO COUNTY

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COVER LETTER for

1) FAMILY INFORMATION FORMS and
2) AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION form.

1) FAMILY INFORMATION FORM: On October 4, 2001 Assembly Bill 1424 (Thomson) was signed by the Governor and chaptered into law (Welfare & Institutions Code sec. 5150.05). The law became effective Jan. 1, 2002. Now 5150.05 modifies the LPS Act (Lanterman, Petris, Short Act), which governs involuntary treatment for people with mental illness in California.

> **Family members need to be aware *that their input shall be considered in determining if involuntary treatment is appropriate, and that they may not knowingly give false information without being potentially liable to their mentally ill family member in a civil action*.**

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2) AUTHORIZATION FOR THE VERBAL RELEASE OF PROTECTED HEALTH INFORMATION FORM was developed as a tool that can facilitate communication between mental heatlh care providers and the family or other care givers. It may be presented to outpatient care providers as well as hospitals. The care provider or facility may have their own forms and require your family member to sign a new authorization for release of information to you.

Note: We suggest, as a guideline, that you fill out the forms in advance, keep the information current, have extra copies, and, if possible have the currently treating physician check the information.

If your family member is admitted to a 24-hour licensed public or private facility, by law the facility shall notify the next of kin or any other person designated by the patient, of the patient's admission, unless the patient requests that this notification not be provided.

******The "Fact sheet on California Law 5150.05" and the Family Information form was developed by Nami San Mateo County, San Mateo County Mental Health Division and client organizations to facilitate this communication.* ***Nami El Dorado County*** *is providing this form for the El Dorado County Mental Health Department and for Families of the Mentally Ill in our County.*

California 5150.05

On October 24, 2001 Assembly Bill 1424 (Thomson-Yolo D) was signed by the Governor and chaptered into law. The law became effective January 1, 2002. Now California Law 5150.05 modifies the LPS (Lanterman, Petris, Short Act), which governs involuntary treatment for people with mental illness in California. Quoting the legislative intent of the bill,
"The legislature finds and declares all of the following: Many families of persons with serious mental illness find the Lanterman-Petris-Short Act system difficult to access and not supportive of family information regarding history and symptoms. Persons with mental illness are best served in a system of care that acknowledges and supports the role of the family, including parents, children, spouses, significant others, and consumer identified natural resource systems. It is the intent of the Legislature that the Lanterman-Petris-Short Act system procedures be clarified to ensure that families are a part of the system response, subject to the rules of evidence and court procedures." More specifically, 5150.05 requires:

- That the historical course of the person's mental illness be considered when it has a direct bearing on the determination of whether the person is a danger to self/others or gravely disabled;

- That relevant evidence in available medical records or presented by family members, treatment providers, or anyone designated by the patient be considered by the court in determining the historical course;

- That facilities make every reasonable effort to make information provided by the family available to the court;

- That the person (a law enforcement officer or designated mental health professional) authorized to place a person in emergency custody (a "5150") consider information provided by the family or a treating professional regarding historical course when deciding whether there is probable cause for hospitalization. Upon the signing of AB 1424, several W &I codes were amended to permit relevant information about the historical course of a person's mental disorder from any source to be considered at all stages of the involuntary hospitalization process. For example, W & I code 5150.05 was added to 5150. It says:

(a) When determining if probable cause exists to take a person into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person, to be taken into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder pursuant to Section 5150.05

Communicating with Mental Health Providers about Adult Mental Health Patients

Nami El Dorado County recognizes the key role families play in the recovery of mentally ill individuals receiving mental health services. We encourage providers at every level of care to seek authorization from the patient so that the family will be involved and informed in their care. In fact, we have a special authorization form expressly designed to facilitate communication between treatment teams and family members. We hope the summary below clarifies how laws concerning confidentiality affect communications between families and mental health providers concerning mental health patients aged 18 or older.

- California and Federal law require that mental health providers obtain authorization from the patient before they are able to communicate with family members, even to reveal that person is a patient.
- California law requires that hospitals inform families that a family member has been admitted, transferred, or discharged unless the patient requests that the family not be notified.
- California and Federal law require that hospital staff obtain an authorization to disclose anything else to family members.
- **Although mental health providers are constrained in their ability to communicate with families, family members may communicate with treatment teams with or without an authorization from the patient.**
  - This form can be used to provide information about the patient to hospital or outpatient staff. Staff will place this information in the patient's mental health chart. Under California and Federal law, patients have the right to view this chart.

AUTHORIZATION FOR THE VERBAL RELEASE OF HEALTH INFORMATION TO FAMILY, FRIENDS, OR INDIVIDUALS PROVIDING SOCIAL SUPPORT

(Confidential Patient Information: See California Welfare and Institution Code (WIC) Section 5328)

Name of Client/Patient ____Social Security # ________________

Address: _________________________________ City/State _______________________Zip: ____________

Date of Birth: ________________ Medical Number (if available): ___________________________________

I hereby authorize Mental Health Treatment Providers to **verbally** discuss the following information obtained in the course of my psychiatric and/or drug and alcohol assessment and treatment to the designated person(s):

my general status in the treatment program; my general physical and mental health; my goals in the program;

my medication; how to support my progress in the program; special problem areas; hospitalization (admission and release)

The above indicated information may be verbally discussed only with the following designated person(s):

Name ____

Address _______________________________City/State/Zip _______________________________________

Phone/Email: ____ Relationship _____________________

This consent is limited to the release of **verbal** information only. Release of the specified **verbal** information to any person not specified is prohibited. An additional written consent must be obtained for a proposed new use of the verbal information or for its transfer to another person.

This authorization shall be valid until consent is withdrawn in writing.

____

Client/Patient Signature/Date

____

Witness (Name) Signature/Date

___________________________ ____

Signature of Designated Person(s) Date

Information Provided by Family Member

This form was developed to provide a means for family members to communicate about their relative's mental health history pursuant to **California Law 5150.05** which requires all individuals making decisions about involuntary treatment to consider information supplied by family members. Mental Health Staff will place this form in your family member's mental health chart. Under California and Federal Law, patients/clients have the right to view their charts.

Name of Family Member ________________________________ Date of Birth _____________

Phone ________________Address ____

Medi-Cal ☐ Yes ☐ No Medicare ☐ Yes ☐ No

Name of Private Medical Insurer
____

☐ Yes ☐ No Please ask my relative to sign an authorization permitting El Dorado County Mental Health Providers to communicate with me about his/her care.

☐ Yes ☐ No I wish to be contacted as soon as possible in case of emergency, transfer or discharge.

☐ Yes ☐ No My relative has a Wellness Recovery Plan or Advanced Directive. (If yes, and a copy is available please attach a copy to this form.)

Brief history of mental illness: (diagnosis, age of onset, previous capabilities and interests, danger to self or others, grave disabilities): **Use additional page if necessary.

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Does family member have a Conservator ☐ Yes ☐ No If yes, (Name & Phone# ____________
____

Do you know of any substance abuse problem ☐ Yes ☐ No

List current medications (psychiatric & medical):____

Medications family member has responded well to _______________________________________

Medications that did not work ____

Treating Psychiatrist _______________________________________Phone #________________

Treating Case Manager______________________________________ Phone #________________

Information Provided By Family Member

(continued)

Name of Family Member: ______________________________ Date of Birth: ____________________

Significant Medical Conditions____

Allergies to Medications, Food, Chemicals, Other____

____

Primary Care Physician____ Phone_________________

Current Living Situation____

Description of Crisis Behavior/Events, Action Taken and Results (if multiple crisis/events use additional page:

Date_____________ Crisis Behavior/Event ____

____

____

____

Action Taken_____________________________________ Results of the Action __________________

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____

What has helped your family member deal with these crises? ________________________________

____

What has not been helpful? ____

____

Information Submitted By:

Name (Print)___________________________________ Relationship to Relative _________________

Address____ Phone _____________________

Signature/Date____