Blackfeet Tribal Behavioral Health

#12 Starr School Road
Browning, MT. 59417
P: (406) 338-2160 / F: (406)338-2006
Email: behavioral-health@blackfeetnation.com

Consent to Treatment and Release of Information

1. I **consent** to Blackfeet Tribal Behavioral Health (BTBH) providing mental health and substance use evaluations and therapy, peer support education, and other consultation services that fall under their scope of practice and mission. If the patient is an adolescent, my signature will acknowledge my authorization to treat my child if I am not reasonably available by telephone to consent.

2. I understand that Protected Health Information (PHI) may be shared electronically, by phone, or by letter following all HIPAA, Federal Confidentiality, and 42 CFR, Part 2 laws. That might include other providers (even a non-covered entity) to facilitate that provider's *treatment* activities, that party's *payment* activities, or some of that entity's *healthcare operations*—additional exceptions include arrangements within the same organized healthcare arrangement for any healthcare *operations*. Essentially, this is treatment, payment, and operations (TPO). Therefore, I give consent to Blackfeet Tribal Behavioral Health to release any information that pertains to patient care.

3. BTBH provides on-site or via telehealth services at #12 Starr School Road; however, if telehealth therapy is necessary, I recognize this experience may differ from other treatment services. If I am recommended to participate in telehealth treatment, I consent to accept this treatment method and the risks of technical difficulties or service disruption.

4. I have the **right to refuse** any treatment offered by Blackfeet Tribal Behavioral Health if I do not feel comfortable and can withdraw or withhold my consent. By doing so, this will not affect future services.

5. This consent also allows Blackfeet Tribal Behavioral Health (BTBH) to **transport** my child from their school or in an emergency if this service is applicable.

6. Lastly, as the patient or parent/legal guardian of a patient, I understand that it is our right to revoke our consent at any time if we disagree with treatment or how our health information is shared.

By signing this form, I acknowledge that I have read, understand, and agree to the information provided to me.

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_____ _____
Patient Name Effective Date

_____ _____
Parent/Legal Guardian *(If the patient is a minor)* Effective Date

_____ _____
BTBH Staff Signature Effective Date

Revised: 10/1/2024