


| Policy and Procedure Manual Saginaw County Community Mental Health Authority | | |
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| Subject: Recipient Rights – Voice Recording, Photography, Fingerprinting, and the use of One-Way Glass | Chapter: 02 - Customer Services and Recipient Rights | Subject No: 02.02.18 |
| Effective Date: March 7, 2000 | Date of Review/Revision: 2/19/03, 1/25/08, 6/29/09, 6/22/12, 6/14/14, 11/27/16, 6/1/18, 1/8/19, 2/11/20, 2/9/21, 5/10/22 | Approved By: Sandra M. Lindsey, CEO |
| | Supersedes: 06.02.21.00 | |
|  | | Responsible Director: Tim Ninemire, Director of Customer Services & Recipient Rights |
| | | Authored By: Tim Ninemire |
| | | Additional Reviewers: None |

Purpose:

The purpose of this policy is to set limits and guidelines for the use of voice recording, fingerprinting, and the use of one-way glass in the treatment of consumers receiving mental health services from Saginaw County Community Mental Health Authority (SCCMHA) or any of its Service Provider Network.

Policy:

It is the policy of SCCMHA that the use of voice recording, fingerprinting, and one-way glass will not be used without the expressed written consent of the consumer, their guardian, parent of a minor or loco parentis.

Application:

This policy applies to all SCCMHA direct operated programs as well as all Provider Network programs.

Standards:

- E1) Fingerprints, photographs, or audiotapes may be taken and one-way glass may be used only when prior expressed written consent is obtained from the consumer, their guardian, parent of a minor or loco parentis.
- E2) Fingerprints, photographs, or audiotapes may be taken and one-way glass may be used in order to determine the identification of the consumer as set forth in Procedure #4 below.

- E3) Written consent is required for the use of fingerprints, photographs, audiotapes, or one-way glass. This written consent will be obtained from the consumer, their guardian, parent of a minor or loco parentis.
- E4) Consent for the use of fingerprints, photographs, audiotapes, or one-way glass may be withdrawn at any time.
- E5) Photographs (videos are excluded) may be taken for purely personal or social purposes. However, photographs taken will not be posted on social media or for any public viewing without prior expressed written consent. A photograph of a consumer shall not be taken or used if the consumer has indicated his or her objection.
- E6) The safekeeping of fingerprints, photographs, or audiotapes is described in Procedures #3, 4, & 5 below.
- E7) Fingerprints, photographs, or audiotapes in the record of a consumer, and any copies of them, shall be given to the consumer, or destroyed when they are no longer essential to achieve one of the objectives set forth in subsection (E2), or upon discharge of the resident, whichever occurs first.
- E8) The consent for the use of fingerprints, photographs, audiotapes, or one-way glass will be considered valid for one year from the date of the initial signature. However, the Assigned Support Staff will make known to the consumer, their guardian, parent of a minor or loco parentis each time any of these methods are being used and the consent can be withdrawn at any time as stated in Standard E4.
- E9) This policy prohibits video surveillance when recording is occurring and in non-public areas.
- E10) All consumer consents related to fingerprints, photographs, audiotapes, one-way glass, or written information for SCCMHA publications will be completed by using the Regional Release form in sentri II.

Definitions:

Assigned Support Staff: Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA consumer. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff person or a member of the SCCMHA Service Provider Network.

Loco Parentis: A person or institution that assumes parental rights and duties for a minor.

Photography: Still pictures, motion pictures, and videotapes

Social Media: Social interaction among people in which they create, share or exchange information and ideas in virtual communities and networks.

References:

Administrative Rules 7003

Michigan Mental Health Code 330.1724

Exhibits:

Exhibit A - SCCMHA Release of Information

Procedure:

| ACTION | RESPONSIBILITY |
|--|---|
| 1) The rights of consumers receiving mental health services are clearly protected under the Michigan Mental Health Code in specific regard to fingerprints, photographs, use of one-way glass, and audiotapes. It is the duty of the SCCMHA Recipient Rights Office to ensure these rights are upheld. | 1) Recipient Rights Office |
| 2) Any use of fingerprints, photographs, audiotapes, or of one-way glass without the expressed written consent of the consumer, (if 18 years of age or over and competent to consent), their guardian, the parent of a minor, or loco parentis is expressly prohibited. | 2) Enforced by the Recipient Rights Office |
| 3) In the event that fingerprints, photographs, or audiotapes are taken in order to provide services to a consumer, all copies of them shall be kept as part of the record of the consumer. | 3) Assigned Support Staff |
| 4) If fingerprints, photographs, or audiotapes are necessary for determining the name of a consumer, these will be kept as part of the record. If necessary, the fingerprints, photographs, or audiotapes may be delivered to others for assistance in determining the identity of the consumer. Upon completion of the use of the fingerprints, photographs, or audiotapes, together with copies, will be kept as part of the record of the consumer. | 4) Assigned Support Staff in conjunction with the Director of the Recipient Rights Office |
| 5) Fingerprints, photographs, or audiotapes in the record of a consumer, and any copies of them, will be given to the consumer or destroyed when it is no longer essential in | 5) Assigned Support Staff in conjunction with their Supervisor and the Medical Records Unit |

order to achieve one of the objectives set forth in standard number E2 of this policy or upon discharge of the consumer, whichever occurs first.

Exhibit A



Authorization to Exchange PHI



| IDENTIFYING INFORMATION | | | | |
|---|-------------------|-----------|---------------------|------------------|
| NAME Consumer W. Twelve | DOB 08/18/1989 | AGE 28 | CASE # 000000012 | GENDER Female |
| ADDRESS 500 Hancock Suite 1, SAGINAW, MI 48605 | | | | |

| DOCUMENT DATE |
|---------------|
| 05/10/2018 |

| AUTHORIZATION |
|--|
| I authorize SCCMHA and Hope Network to Send and Receive the specified information to/from the person/organization(s) named below |

| PERSON |
|------------------------|
| NAME ME |
| PHONE NUMBER |
| ALTERNATE PHONE NUMBER |

| INFORMATION TO BE MADE AVAILABLE: |
|--|
| <input checked="" type="checkbox"/> Entire Record |
| <input type="checkbox"/> Entire Record EXCEPT the following types of documents |
| <input type="checkbox"/> Only these types of documents |

TIME FRAME OF RECORDS NEEDED

| |
|--|
| I understand that this health information may include information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to: |
| <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Substance Abuse (including alcohol / drug abuse) |
| <input type="checkbox"/> HIV |

RESTRICTIONS

The information indicated will be disclosed unless there are specific restrictions noted here

| PURPOSE OR NEED FOR THE DISCLOSURE (CHECK ALL THAT APPLY) |
|---|
| <input checked="" type="checkbox"/> Acquisition of Services or Benefits |
| <input checked="" type="checkbox"/> Coordination Of Care |
| <input type="checkbox"/> Patient Request |
| <input type="checkbox"/> Other: |

09/07/2018



- I understand there is a possibility the protected health information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules.
 - I understand that medical information may include mental health treatment records, substance abuse information, information about serious communicable diseases or infections including HIV/AIDS, ARC, Tuberculosis, Hepatitis B, and Venereal Disease as permitted by law.
 - I understand that treatment, payment, enrollment or eligibility for services will not be conditioned upon the signing of this authorization.
 - I understand that this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent that action has already been taken. To revoke an authorization, I need to notify the SCCMHA Medical Records Department.
 - I understand that this authorization will expire (Select one**):
 - ☒ One year from this date (i.e., date of signature)
 - ☐ On the following date:
 - ☐ Upon the following specific event (describe):
- **Note:** If neither a specific date or a specific event is selected, this Authorization will automatically expire 60 days after discharge or one year from the date of authorization, whichever comes first.

Note to Recipient of Disclosed Mental Health Information: This disclosed information is protected by the Mental Health Code 330.1748. An individual receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

Note to Recipient of Disclosed Substance / Alcohol Abuse Information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (52 FR 21809, June 9, 1987; 52 FR 41997, Nov 2, 1987)

I understand that my alcohol and/or drug treatment records are protected under Federal confidentiality rules (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 CFR Parts 160 & 164. Information about my mental health status is confidential and is protected by the Michigan Mental Health Code PA 258 of 1974, section 78 (3), PA 488 of 1988, effective 3/30/1989-42 CFR 455, Part B. Information about my medical condition, including status of serious communicable disease or infections such as HIV and acquired immunodeficiency syndrome, is confidential and protected under the Michigan Public Health Code PA 368. This information cannot be disclosed without my written consent unless otherwise provided for in the regulations.

SIGNATURES

| | | |
|--------------------|--------------|------------|
| | | 05/10/2018 |
| CONSUMER SIGNATURE | PRINTED NAME | DATE |

| | | |
|-------------------|--------------|------------|
| | | 09/07/2018 |
| WITNESS SIGNATURE | PRINTED NAME | DATE |

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