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<tr><th colspan="3">olicy and Procedure Manual<br>Saginaw County Community Mental Health Authority</th></tr>
<tr><td>Subject: Recipient Rights - Voice Recording, Photography, Fingerprinting, and the use of One-Way Glass</td><td>Chapter: 02 - Customer Service and Recipient Rights</td><td>Subject No: 02.02.18</td></tr>
<tr><td rowspan="2">Effective Date:<br>March 7, 2000</td><td>Date of Review/Revision:<br>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, 3/14/23, 3/12/24, 4/8/25, 3/10/26</td><td rowspan="3">Approved By:<br>Sandra M. Lindsey, CEO<br><br>Responsible Director:<br>Kentera Patterson, Officer of Recipient Rights<br><br>Authored By:<br>Kentera Patterson, Officer of Recipient Rights<br><br>Additional Reviewers:<br>Judy Sausedo, Supervisor of Recipient Rights</td></tr>
<tr><td>Supersedes:<br>06.02.21.00</td></tr>
<tr><td colspan="2">SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY</td></tr>
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**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 people served 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 person served, 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:**

1) Written consent is required for the use of fingerprints, photographs, audiotapes, or one-way glass. Fingerprints, photographs, or audiotapes may be taken, and one-way glass may be used only when prior expressed written consent is obtained from the person served, their guardian, parent of a minor or loco parentis.

2) Fingerprints, photographs, or audiotapes may be taken, and one-way glass may be used to determine the identification of the person served as set forth within this policy.

3) Consent for the use of fingerprints, photographs, audiotapes, or one-way glass may be withdrawn at any time.

4) Photographs (videos are excluded) may be taken for pure 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 person served shall not be taken or used if the person served has indicated his or her objection.

5) The safekeeping of fingerprints, photographs, or audiotapes is described in the procedure section of this policy.

6) Fingerprints, photographs, or audiotapes in the record of a person served, and any copies of them, shall be given to the person served, or destroyed when they are no longer essential to achieve one of the objectives set forth within this policy , or upon discharge of the person served , whichever occurs first.

7) 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 person served, 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.

8) This policy prohibits video surveillance when recording is occurring and in non-public areas.

9) All persons served consents related to fingerprints, photographs, audiotapes, one-way glass, or written information for SCCMHA publications will be completed by using the MDHHS-5515 - Consent to Share Behavioral Health Information link in Sentri II.

10) Fingerprints, photographs, or audiotapes may be taken and used and one-way glass may be used in order to provide services, including research, to a person served or in order to determine the name of the person served only when prior written consent is obtained.

**Definitions:**

**Assigned Support Staff:** Case Manager, Support Coordinator, or Therapist assigned to work with a SCCMHA person served. The Case Manager, Support Coordinator, or Therapist may be a SCCMHA staff member 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 - Consent to Share Behavioral Health Information

**Procedure:**

| ACTION | RESPONSIBILITY |
|---|---|
| 1) The rights of people served 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 person served, (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) Recipient Rights Office |
| 3) If fingerprints, photographs, or audiotapes are taken in order to provide services to a person served, all copies of them shall be kept as part of the record of the person served. | 3) Assigned Support Staff |
| 4) If fingerprints, photographs, or audiotapes are necessary for determining the name of a person served, these will be kept as part of the | 4) Assigned Support Staff in conjunction with the Officer of Recipient Rights |

| | |
|---|---|
| record. If necessary, fingerprints, photographs, or audiotapes may be delivered to others for assistance in determining the identity of the person served. Upon completion the use of the fingerprints, photographs, or audiotapes, together with copies, will be kept as part of the record of the person served. | |
| 5) Fingerprints, photographs, or audiotapes in the record of a person served, and any copies of them, will be given to the person served or destroyed when it is no longer essential in order to achieve one of the objectives set forth within this policy or upon discharge of the person served, whichever occurs first. | 5) Assigned Support Staff in conjunction with their Supervisor and the Medical Records Unit |

Exhibit A

**Saginaw County Community Mental Health Authority**

Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

**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 this 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.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

**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, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3, and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it to your health care provider. They can make a copy for you.

**SECTION 1 - ABOUT YOU**

| Name (First, Middle Initial and Last) | Date of Birth |
|---|---|
| Janet W. Doe | 07/04/1988 |

**SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)**

Sharing information between individuals and organizations

**Consent for All Future Uses for Treatment, Payment, and Health Care Operations**

☐Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

**Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.**

This consent expires (optional)
03/12/2027

When providing a consent for treatment, payment, and health care operations there is the potential for records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected under 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are

**SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT**

**A. 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.**

Health Plan

Pre-paid Inpatient Health Plan (PIHP)
Mid-State Health Network

1. Saginaw
   500 Hancock Street Saginaw, MI 48602-4224
   Phone: 989-797-3400 Fax: 989-799-0206

**B. 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 3a

☐ 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.

**For Health Care Provider or Health Plan Use Only.** List all health information exchanges or networks:

1. PCE Systems
2. Michigan Health Information Network

**SECTION 4 - 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 and/or substance use disorder counseling notes."

☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

**The expiration date, event, or condition for Sections 3 and 4**

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

<ONE YEAR FROM SIGNATURE DATE>

**SECTION 5 - 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/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my heath 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 and/or with substance use disorder counseling 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.

Electronically Signed By:
Kentera Patterson BS — STAFF SIGNATURE / CREDENTIALS
03/17/2026 — DATE

CONSUMER SIGNATURE | PRINTED NAME | DATE

PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE | PRINTED NAME | DATE

WITNESS SIGNATURE | PRINTED NAME | DATE

## SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

Signature Date

## SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

**Verbal Withdraw of Consent**

☐The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed in Section 1
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

Print name of person who received the verbal withdrawal

Signature Date

**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

**Additional Identifiers (Optional)**

| Medicaid | Last 4 of the Social Security Number | Case # |
|---|---|---|
| 000123456789 | *****9998 | 000000012 |

**Form Copy (choose one option)**

☒ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, national origin, color, sex, disability, religion, age, height, weight, family status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

**AUTHORITY:** This form is acceptable to 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.

**COMPLETION: Voluntary but required of disclosure is requested.**