BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

LEESBURG - SUMTERVILLE

Please fill out this form as completely as you can. Please bring this completed form to your first appointment. The information shared will be kept confidential according to our privacy policy.

Patient Name_____

Date of Birth_____ Age_____ Gender _____Male _____Female

SSN_____Marital Status_____

Patient's School or Employer Name_____

Primary Insurance

Member's Name_____

Policy#_____Group#_____

Member's SSN _____Date of Birth_____

Secondary Insurance

Member's Name_____

Policy#_____Group#_____

Member's SSN _____Date of Birth_____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP_____ HOME

PHONE_____ CELL

PHONE_____EMAIL_____

Guardian's Name_____ Relationship to Patient_____
Guardian's phone number_____

Guardian's Name_____Relationship to Patient_____
Guardian's phone number_____

If Patient is of legal age and is not his/her own guardian, please explain and provide documentation to Better Life Behavioral Services.

_____

_____

Patient resides with_____
Emergency Contact Name_____Emergency Contact Number_____

Primary Care Physician Name_____
Primary Care Physician phone number_____
Primary Care Physician fax number_____
Primary Care Physician address_____

Diagnoses/Medical Conditions; Please include any infectious diseases:

_____

_____

Previous Medical Conditions/History (be as comprehensive as possible):

_____

_____

_____

_____

Are you currently being seen by another behavioral health clinician?

❒ Yes

❒ No

If yes, who?_____

Family Medical History

Mother's Name_____

If living, Mother's age_____ If deceased, what age was the child at her death? _____

Father'sName_____

If living, Father's age_____ If deceased, what age was child at his death? _____

Are there any medical conditions of the child's Mother or Father that might be important to know for treatment? Please list:

_____

_____

_____

Current medications:

Medication	Dosage	Time(s) given	Reason	Prescribing Doctor

Does the patient have ANY known allergies? Please list:

_____

_____

_____

What is the reason for the visit?

_____

_____

_____

_____

_____

How long ago did you notice the problems?

_____

_____

_____

Do the problems occur in school?

❒ Yes ❒ No

Do the problems occur at home?

❒ Yes ❒ No

How do you currently handle the problems?

❒ Yes ❒ No

Please elaborate:

_____

_____

_____

Please list the 3 most important goals for treatment:

1. _____
   _____
2. _____
   _____
3. _____
   _____

What are the patient's strengths?

_____
_____
_____

Please list the patient's favorite items, activities, and foods (please include at least 3 favorite foods). _____
_____
_____
_____

Siblings Name	Age	Any disability?

Are there any significant childhood events that the patient has experienced?

_____
_____
_____
_____

Were there any complications during pregnancy or birth?

_____

_____

_____

At what age did the patient reach the following developmental milestones? Sitting up _____

Crawling _____

Walking _____

Talking _____

Toilet Training _____

Please list any delays in development that have been noticed by guardians, pediatricians or other professionals

_____

_____

_____

Please describe patient's development for the following areas as average, below average, or above average:

Social _____

Physical _____

Intellectual _____

Emotional _____

Language _____

Please describe the school setting:

_____

_____

_____

Does your child have a current IEP or Educational Assessment?

❒ Yes ❒ No

Does your child receive treatment from any other specialists or doctors? (e.g., PT, OT, SLP, neurologist, etc.) Please list specialist names.

_____

_____

_____

_____

_____

In your opinion, on a scale of 1 to 10, 10 being most significant, how significantly do the problems interfere with the patient's learning? _____

In your opinion, on a scale of 1 to 10, 10 being most significant, how significantly do the problems interfere with the patient's social relationships? _____

In your opinion, on a scale of 1 to 10, 10 being most significant, how significantly do the problems interfere with the patient's family relationships? _____

List any other areas that are affected:

_____

_____

_____

Are there any spiritual or cultural preferences that you believe might impact treatment? ❒ Yes ❒ No

_____

_____

Is there any other information that is important to consider during treatment? ❒ Yes ❒ No

_____

_____

Are there any family legal issues (e.g., divorce, child custody, orders of protection)?

❒ Yes ❒ No

If yes, please explain _____

_____

What are your current community or family supports?

_____

_____

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Better Life Behavioral
Services of Central FL

Agreement to Pay for Professional Services

I request that Better Life Behavioral Services of Central Florida, LLC provide professional services to me (or for minors or dependents: for Applied Behavior Analysis Services), and I agree to pay this professional's fee of $95.00 per hour assessments and treatment sessions, or a co-pay/co-insurance amount of _____, if I am using insurance. I authorize Better Life Behavioral Services to bill my insurance company on my behalf.

I agree that I am responsible for the charges for services provided by this therapist, although other persons or insurance companies may make payments on my (or this client's) account. If I am using insurance, I understand that the office staff and my provider will make their best effort to help me find out what is my mental health coverage and help me with necessary authorizations, etc., but that ultimately I am responsible for payment for services rendered.

I agree that this financial relationship will continue as long as the Behavior Analyst provides services or until I inform him or her, in person, by telephone or by certified mail, that I wish to end service provision. I agree to pay for services provided up until the time I end the relationship.

I agree to pay with check or cash unless otherwise notified that credit cards are

accepted. I agree to pay a $35.00 fee for any returned checks.

Missed Appointment/Late or Early Pick-Up Policies

If I do not show up or cancel a scheduled appointment with less than 24 hours' notice:

- The first occurrence will be no charge.
- The second occurrence I will be charged a $95 missed session fee.
- And the third occurrence I will be charged a $95 missed session fee.
- If this occurs more than three times in a rolling 90 day period, I will be charged $95, Better Life Behavioral Services of Central Florida will withdraw from the provision of services, and I will be placed at the bottom of our waiting list. I understand that if there are extenuating circumstances, my provider may choose to waive the missed session fee on a case-by-case basis.

If I am 30 or more minutes late for an appointment without contacting BLBS by my scheduled session time:

- The first occurrence will be no charge.
- The second occurrence I will be charged $95/hour for the time missed.
- And the third occurrence I will be charged $95/hour for the time missed.
- If this occurs more than three times in a rolling 90 day period, I will be charged $95/hour for the time missed, Better Life Behavioral Services of Central Florida will withdraw from the provision of services, and I will be placed at the bottom of our waiting list. I understand that if there are extenuating circumstances, my provider may choose to waive the fee on a case-by-case basis.

If I pick my child up 30 or more minutes before his/her scheduled session end time, without notifying BLBS at least 24 hours in advance:

- The first occurrence will be no charge.
- The second occurrence I will be charged $95/hour for the time remaining in the scheduled session.
- And the third occurrence I will be charged $95/hour for the time remaining in the scheduled session.
- If this occurs more than three times in a rolling 90 day period, I will be charged $95/hour for the time remaining in the scheduled session, Better Life Behavioral Services of Central Florida will withdraw from the provision of services, and I will be placed at the bottom of our waiting list. I understand that if there are extenuating circumstances, my provider may choose to waive the fee on a case-by-case basis.

If I pick my child up 15 or more minutes after his/her scheduled session end time, without notifying BLBS at least 24 hours in advance:

- The first occurrence will be no charge.
- The second occurrence I will be charged $95/hour for the time following the scheduled session until pick-up time.
- And the third occurrence I will be charged $95/hour for the time following the scheduled session until pick-up time.
- If this occurs more than three times in a rolling 90 day period, I will be charged $95/hour for the time following the scheduled session until pick-up time, Better Life Behavioral Services of Central Florida will withdraw from the provision of services, and I will be placed at the bottom of our waiting list. I understand that if there are extenuating circumstances, my provider may choose to waive the fee on a case-by-case basis.

I have also read the family contract for services form and agree to act according to the terms stated there, as shown by my signature below and on that form.

_____ _____

Signature of Client or Clients Date

_____

Printed Name

I, the Behavior Analyst, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Behavior Analyst Date

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 West Main Street Unit 1 Leesburg, FL 34748

(352) 314-3760

AUTHORIZATION TO RELEASE INFORMATION

Patient/Client Name: _____DOB:_____

Street Address: _____City/State_____ZIP_____

I understand this release is voluntary and applies to all programs and services operated under the auspices of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations.

I understand that I may revoke this authorization at any time by notifying BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.

I hereby authorize BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC to (check all that apply):

❒ Exchange with ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC to exchange / release / obtain information:

❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

Organization or Individual receiving/communicating the information:

_____

Name of Organization/Individual

_____

Address City, State Zip Phone

Description of information to be exchanged / released / obtained:

❒ Education records

❒ Evaluation/assessment/eligibility records

❒ Medical records

❒ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies) ❒ Other

Duration of release (check one):

❒ This release will remain in effect as long as the above patient/client receives services from Better Life Behavioral Services, unless otherwise stipulated or revoked in writing.

❒ From (MM/DD/YYYY) _____ To (MM/DD/YYYY)_____

The purpose if this release is:

_____

_____

_____

_____

Signature of Patient/Client/or Legally Authorized Representative **Date**

_____

PRINT NAME and Relationship of Legally Authorized Representative to Student/Consumer/Patient

Better Life Behavioral Services of Central FL

1650 W Main St., Unit 1
Leesburg, FL 34748
(352) 314-3760

Release of Medical Information

This release is in reference to your or your child's private medical information. Please read it carefully.

Terms of Acknowledgement and Agreement for Center and Community-Based Services:

Center-based services: Your child will receive therapy alone or in groups or group areas in which there are others receiving therapy at the same time. During therapy for your child, there will be interaction with other therapists and other patients receiving therapy.

Community-based services: Your child will receive therapy in the community.

You acknowledge and understand that by agreeing to receive center-based or community-based services, you also agree to the release of the following private health information (PHI) due to the potential of others* being present in the service delivery vicinity (center or community). PHI released may include, but is not limited to:

- Various modes of electronic recording not limited to cell phone video, Catalyst recording or audio recording that is intended to share with caregivers or for clinical purposes.
- Others that may be in the service delivery vicinity (center or community) may observe or hear therapy for you/your child as it is being conducted. This includes information shared between employees of Better Life Behavioral Services during programming hours.

- Others that may hear communication between staff about your child's treatment that is necessary to exchange to ensure services are provided effectively. This will occur during supervision of therapy or collaboration with or from one therapist to another.
- Others that may observe your child engaging in appropriate/inappropriate behaviors or learning activities.
- Other unforeseen releases or disclosures that may occur while in the community.

*Others that might be in the service delivery vicinity include parents of other children, siblings, caregivers, relatives, other patients we provide services to, and private service providers from other companies providing such services during our sessions (clinic or community).

We will work diligently to protect your child's privacy and private health information by minimizing those in the vicinity when children are having difficulties. We will also refrain from sharing treatment information that is not pertinent to the therapy situation. It should also be understood that as part of ABA services, we may not want to minimize those in the area for therapeutic programming reasons. However, due to the nature of our services and the center and community-based approach, this release of information will likely occur, and it is imperative that you understand the nature of this type of situation.

*Please read the following statement carefully regarding the information that **you** may see or hear.*

There is a potential that you might encounter a child, family or caregiver that you might have seen receiving services. You should be responsible with any private health information that you might come in contact with incidentally while in the clinic or community setting. Responsible regard for information includes but is not limited to:

- not discussing what you have seen or heard with anyone
- avoiding comments or suggestions to the parent or caregiver
- making statements such as "I recognize that kid from the therapy center"
- making defaming remarks related to behaviors or judgements about the child's outcome

I am aware that the release of this private health information is necessary for Better Life Behavioral Services to provide my child/me with opportunities to learn new behaviors, for the socialization goals of my child, to reduce problem behavior, and for other necessary needs during ABA treatment.

Should you have any specific concerns, or you would like to withdraw your release of this information, please speak with Cheryl Ecott, privacy officer at Better Life Behavioral Services. You may withdraw consent for release of this information at any time in writing.

This release will remain in effect as long as I am, or my child is receiving services with Better Life Behavioral Services.

I understand that I am releasing personal health information that might be shared due to the nature of receiving services in a center/community-based facility. I understand that I can withdraw my consent at any time. I have had the opportunity to ask questions regarding this release.

Parent/Guardian_____Date_____

Parent/Guardian_____Date_____

Witness_____Date_____

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 W. MAIN ST. UNIT 1 LEESBURG, FLORIDA 34748

POLICY ON DISCLOSURE OF INFORMATION ABOUT INFECTIOUS DISEASES IN HOUSEHOLD

Patients, parents, or guardians are required to disclose to BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC if a member of the household in which treatment will be provided has a chronic infectious disease OR if an acute infectious disease has been recently acquired and diagnosed. Included in this disclosure is information necessary for staff at BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC to plan for the necessary safety precautions to prevent or limit exposure.

By signing this you acknowledge that you are aware of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA'S policy on disclosure of information about infectious diseases in household.

Patient/Parent/Guardian_____ Date_____

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 WEST MAIN STREET UNIT 1, LEESBURG, FL 34748
(352) 314-3760

Medical Information Release Form (HIPAA Release Form)

Name: _____Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.
This information may be released to:
[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

Messages
Please call [ ] my home [ ] my work [ ] my cell
Number:_____ If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

Duration of Release
[ ] This release will remain in effect for (6) months, unless otherwise stipulated or revoked in writing.
[ ] From (MM/DD/YYYY)_____ to (MM/DD/YYYY)_____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: _____

Witness:_____ Date: _____

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 West Main Street Unit 1 Leesburg, FL 34748

(352) 314-3760

Fax (352) 314-2909

CONSENT FOR APPLIED BEHAVIOR ANALYSIS SERVICES

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the Behavior Analyst Certification Board's Guidelines for Responsible Conduct of Behavior Analysts. I will receive a copy of this document to retain for my records. All fees for services and payment arrangements will be reviewed separately.

I, _____, agree to have my child/dependent, _____, participate in applied behavior analysis (ABA) assessment and/or treatment services provided by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC. I understand that the specific activities, goals, and desired outcomes of these ABA services will be fully discussed with me and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation in services. I also understand that my child/dependent is the primary client of the behavior analyst and that services will be designed primarily for _____'s benefit. Any other individuals

or agencies (e.g., family, school professionals) who may be affected by the ABA services are considered secondary clients.

If the ABA services focus on increasing _____'s skills, I understand that the first several sessions will consist of assessment activities designed to (a) evaluate his/her current skills (e.g., curricular assessments) and (b) determine which instructional strategies and interventions are likely to prove most effective (e.g., preference assessments, assessment of prompting strategies). The time allocated to these assessments will result in improved intervention. If the services are designed to improve ongoing problem behaviors, I understand that the beginning of those services will include functional assessment and/or functional analysis activities (e.g., interviews, checklists, direct observations) that are designed to provide information critical to the development of effective treatment procedures. I may be asked to assist in gathering some of this information by recording problem behavior as it occurs. This process may take 3-5 sessions prior to implementing intervention, but will increase the likelihood of effective intervention.

The subsequent services will be focused on development of and implementation of instructional procedures and/or a behavior intervention plan. Prior to implementation, I will receive a printed copy of the results of any assessment and of any proposed instructional procedures or behavior intervention plans for my approval. The contents of those documents will be explained to me fully and any questions I have will be answered to my satisfaction. Subsequent implementation will involve training in the basics of ABA that are important for the intervention, details about the specific components of the ABA intervention, and direct practice in the components for the family, educators, and/or other service providers. Full participation by parents in these implementation and training activities is critical for a successful outcome. Ongoing collection of data will allow evaluation of the effectiveness of the intervention and will assist in developing any revisions that need to be made to ensure a good outcome. Services may also be provided via telephone for specific problems or situations that might be encountered or to exchange information. When treatment goals are achieved, we will discuss the discontinuation of services as we will have achieved our therapeutic objectives. In addition, at regular progress reviews we may also discuss whether continuation of services would be beneficial, and any barriers to continuation.

Behavior analysts are ethically obligated to provide treatments that have been scientifically supported as most effective for individuals with developmental disabilities. I am aware that other interventions that I am pursuing may affect my child's response to ABA treatment. Thus it is important to make the behavior analyst aware of those interventions and to partner with the behavior analyst to evaluate any associated therapeutic or detrimental effects of those interventions.

I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child/dependent receives any services is protected and private information. I am aware that BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may release information without my prior consent if so, ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others. Please review our HIPAA privacy policy.

I understand that the provider agency employs professional staff that, if they are not certified or if they are in need of supervision to perform services as described in guidelines set forth by the BACB, supervision will be provided by a Board Certified Behavior Analyst. I understand that _____'s assessment and treatment services may be observed by other employees as part of ongoing training and quality assurance activities. Events occurring in those sessions will be discussed in closed supervision meetings of professional staff of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC. All individuals attending these staff meetings are bound by the same confidentiality guidelines as BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC in order to protect my privacy and that of my child/dependent. I am aware that a record of the treatment will be maintained, and this record is available to me in written form upon request.

I understand that it may be necessary to audio- or videotape assessment and/or treatment sessions for supervision purposes. In the event that audio- or videotaping is necessary, I will be informed and asked to give written consent prior to taping. I understand that the recorded material will be used only by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC and only for purposes of treatment and training. If the assessment or treatment involves formal research that goes beyond normal evaluation or clinical procedures, I reserve

the right to consent or refuse to participate.

I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect _____'s right to services. In the event of withdrawal, I may request a list of other credentialed providers in the region. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

I am aware that the relationship between provider and client is a professional one that precludes ongoing social relationships.

I may request a copy of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC'S current professional credentials upon request. In addition, any concerns that I have about BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC's performance can be directed to Cheryl Ecott, PhD., BCBA-D.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Parent or Guardian (legally authorized representative) Date

_____ _____
Provider Printed Name Date

_____ _____
Provider Signature & Credentials Date

BCBA Certificate #

Better Life Behavioral Services of Central Florida, LLC

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

CONSENT FOR PHOTO/VIDEO

Dear Parent/Guardian,

During the current school year, your child's image/photograph or wok may be included in a classroom or school project and could be used in one of the following ways:

- Used for training purposes including parent/guardians, caregivers, and employees of Better Life Behavioral Services of Central Florida, LLC or Better Life Academy.
- Used for data collection, including assessing reliability and integrity of procedures used.
- Used for presentation(s) at professional conferences and as a part of research presentation(s).
- Used as a sample project/activity on CDs created by Better Life Behavioral Services or Better Life Academy for use in education workshops and student classrooms.
- Posted on Better Life Behavioral Services of Central Florida, LLC or Better Life Academy website and/or Facebook, Instagram or social media page.
- Videotaped to appear in a school related program to be used by local television, school/county project or community project.
- Used in a printed publication such as a newspaper or magazine.

While your child's name may accompany the photo, no last name or address will be included with your child's picture if/when it is published.

Please sign the release form below. Your permission will grant us approval to publicize without prior notification and remains in effect until revoked.

_____ I/We DO give permission for _____'s photo/video or work to be used as described above.

_____ I/We DO NOT give permission for _____ 's photo/video or work, to be used as described above.

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

Address:_____

City, State, Zip Code:_____

Phone Number:_____ Date:_____

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC
1650 W. Main St. #1
Leesburg, FL 34748

Privacy Official Contact Information
Cheryl Guerrero Ph.D., BCBA-D
(352) 314-3760
cheryl@betterlifeofcentralfl.com

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

_____ Date

_____
Name (Last, first, middle initial) Social Security # or Patient ID

_____
Street address, City, ST, ZIP Code

_____
Primary phone number | Other phone number Email address

Type of Request

☐ Access/copy ☐ Amendment ☐ Restriction
☐ Confidential communication ☐ Accounting of disclosures ☐ Complaint

Please describe the nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) **in detail**.

[Note: If this is an alternative communications request, please list alternative location/address for receiving medical information below.]

_____
_____
_____
_____

Please list BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC staff members that were contacted regarding this matter:

_____
Name Date

_____
Name Date

_____
Signature Date

For Administrative Use Only:

_____
Date received

Action taken _____ _____
Date

_____

Action taken _____ _____
Date

_____

_____ _____
Privacy Official signature Date
Attach additional documentation, if applicable.

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 West Main St. #1 Leesburg, FL 34748

(352) 314-3760

HIPAA Privacy Policy Notice

The purpose of this policy is to provide a written notice of Better Life Behavioral Services of Central Florida's HIPAA privacy policy. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC and its professional staff, employees, trainees, student interns, and volunteers follow the privacy practices described in this notice. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Employees of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC involved in health care operations may have access to your records in an effort to provide the best possible care.

DEFINITIONS

Protected health information (PHI) – Refers to information in your health record that could identify you.

Treatment - when a health care professional provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when a Behavior Analyst consults with another health care provider such as your family physician or another therapist.

Payment – when BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC obtains reimbursement for your healthcare. Examples of payment are when BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations – when BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC discloses your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with our plan, for administering the plan, such as case management, and care coordination. This may include records being reviewed by staff designated by

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC to assure quality of our operations and compliance.

Use – applies to activities within the BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure – applies to activities outside of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC office such as releasing, transferring, or providing access to information about you to other parties.

Psychotherapy Notes- notes that are kept separate from the medical record have special protection.

The term **Behavioral Therapy notes**, as used by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC includes notes taken by the Behavior Analyst about conversations and interactions observed during family or individuals sessions that do not include the normal actions taken by a Behavior Analyst during treatment. Normal actions taken by Behavior Analyst include, but are not limited to, data collection, data analysis, direct observation and assessment that is documented in a commonly used tool (e.g., ABC analysis, graphic analysis). These notes also include a patient's or patient's family's compliance with treatment.

Authorization – means written permission for specific uses or disclosure.

How will BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC use my protected health information (PHI)? BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will use your PHI for purposes outlined as treatment, payment, and health care operations. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request except under the following circumstances: (a) disclosure to or a request by a health care provider for treatment;
(b) disclosure to an individual who is the subject of the information, or the individual's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when the appropriate authorization is obtained. In those instances when BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC is asked for

information for purposes outside of treatment, payment, and health care operations, BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will obtain an authorization from you before releasing this information. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will also need to obtain an authorization before releasing your Behavioral Therapy notes. These notes may be given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Behavioral Therapy Notes) at any time; however, the revocation or modification is not effective until received by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC.

Uses and Disclosures with Neither Consent nor Authorization

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If a Behavior Analyst knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that they report such knowledge or suspicion to the Florida Department of Children and Family Services.

- **Adult and Domestic Abuse:** If a Behavior Analyst knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, they are required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against a Behavior Analyst or employee of BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC with the Florida Department of Health, the Department has the authority to subpoena confidential mental health information from them relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

Your Personal Health Information may also be used for the following purposes, unless you request restrictions on a specific use or disclosure:

- **Appointment Reminder**
- **Notification when an appointment is cancelled or rescheduled by us**
- **For public health purposes**
- **To military command authorities if you are a member of the armed forces or a member of a Foreign military authority**
- **National security and intelligence activities**
- **Protection of the President or other authorized persons for foreign heads of state, or to conduct Special investigations**
- **Psychotherapy notes**

In summary, BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will not disclose any information identifying an individual as being a client or provide any behavioral health or medical information relating to a client's treatment unless: (a) there is written consent from the client or legal representative (parent/guardian), (b) a court order requires disclosure of the information, (c) medical personnel need the information to meet a medical emergency, (d) qualified personnel use the information for the purposes of payment, treatment, healthcare operations, conducting research, management audits or program evaluations, or (e) it is necessary to report a crime or threat to commit a crime or to report abuse or neglect as required by law. Your authorization is required for all other disclosures of protected health information.

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC will maintain your personal behavioral health record for 6 years after the last clinical contact with BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC. If the patient is under the age of 18, those records will be kept for 6 years after the patient turns 18. After this time period, your records will be shredded, burned, or destroyed

in a way that protects your privacy. Until the records are destroyed they may be used, unless you request in writing restrictions on a specific use or disclosure. Your authorization may be revoked at anytime in writing. If you revoke your authorization verbally Better Life Behavioral Services will honor the verbal revocation, however we will ask that you provide us with written revocation within 1 week of verbal revocation.

Your rights regarding the use of your protected health information. You have the following rights regarding the use of your protected health information, PROVIDED, you make a written request to invoke the right on the form provided by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC:

- **Right to request restriction:** You may request limitations from disclosure on your protected health information we may disclose, but BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC is not required to agree to your request. If we agree, we will comply with your request unless the information provided is to provide you with emergency treatment.

- **Right to confidential communications:** You may request communications in a certain way or at a certain location.

- **Right to inspect and copy:** You have the right to inspect and copy your mental health information regarding decisions about your health care. This does NOT include the right to inspect and copy psychotherapy notes. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may charge a fee for copying, mailing and supplies. Under limited circumstances your request may be denied. In the event BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC denies your request to inspect and copy, you may request that another behavioral health professional chosen by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC review the denial. The results of the review will be honored by BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC.

- **Right to request clarification of the record:** If you believe that the information, we have about you is incorrect or incomplete you may ask to add clarifying information. You may request a form to make corrections or additions. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC is not required to accept the information that you provide on the correction/addition form.

- **Right of accounting of disclosures:** You may request a list of the disclosures of your behavioral health information that have been made to persons or entities other than for treatment, payment, or health care operations in the last 6 years.

Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

Requirements regarding this Notice

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC is required to provide you with this Notice that governs our privacy practices. BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC may change its policies or procedures in regard to privacy practices and we will do our best to make you aware of them. If and when changes occur, the changes will be effective for protected health information that we have for you, in addition to protected health information that we receive in the future.

Safeguarding your PHI

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC has many safeguards in place to protect your PHI. We will do our best to keep your information confidential to avoid incidental or accidental disclosures of your information. All employees, interns, and volunteers will be trained on HIPAA laws and BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA'S policies and procedure for safeguarding your PHI.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC. You will not be penalized or retaliated against in any way for making a complaint. A patient also has the right to file a complaint with the Secretary of Health and Human Services toll free at 1-877-696-6775.

Contact

Please contact your Behavior Analyst or BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC to discuss issues of privacy.

If you have a complaint, questions about this notice, you wish to request restrictions on uses and disclosure for health care treatment or operations, or you wish to obtain any of the forms mentioned to exercise your individual rights described above please contact your Behavior Analyst or BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC.

Employee driven complaints will be discussed with a partner at BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC.

BETTER LIFE BEHAVIORAL SERVICES OF CENTRAL FLORIDA, LLC

1650 West Main Street Unit 1 Leesburg, FL 34758

(352) 314-3760 fax (352) 314-2909

This is to confirm that Better Life Behavioral Services of Central Florida has reviewed the Bill of Rights of Persons who are Developmentally Disabled with me/us. I have been fully informed of my/our rights and responsibilities and have been given examples of how to fully exercise my rights and make informed choices, and all of my questions were answered. I was also given a copy of the Agency for Persons with Disabilities Bill of Rights of Persons who are Developmentally Disabled.

_____ _____

Printed Name of Client Signature of Client

_____ _____

Printed Name of Guardian (if applicable) Signature of Guardian (if applicable)

_____ _____

Name of BLBS Representative who reviewed document Date

agency for persons with disabilities
State of Florida

The Bill of Rights of Persons Who Are Developmentally Disabled

393.13 Treatment of persons with developmental disabilities.--

(1) SHORT TITLE.--This section shall be known as "The Bill of Rights of Persons with Developmental Disabilities."

(2) LEGISLATIVE INTENT.--

(a) The Legislature finds and declares that the system of care provided to individuals with developmental disabilities must be designed to meet the needs of the clients as well as protect the integrity of their legal and human rights.

(b) The Legislature further finds and declares that the design and delivery of treatment and services to persons with developmental disabilities should be directed by the principles of self-determination and therefore should:

1. Abate the use of large institutions.

2. Continue the development of community-based services that provide reasonable alternatives to institutionalization in settings that are least restrictive to the client and that provide opportunities for inclusion in the community.

3. Provide training and education that will maximize their potential to lead independent and productive lives and that will afford opportunities for outward mobility from institutions.

4. Reduce the use of sheltered workshops and other noncompetitive employment day activities and promote opportunities for those who choose to seek such employment.

(c) It is the intent of the Legislature that duplicative and unnecessary administrative procedures and practices shall be eliminated, and areas of responsibility shall be clearly defined and consolidated in order to economically utilize present resources. Furthermore, personnel providing services should be sufficiently qualified and experienced to meet the needs of the clients, and they must be sufficient in number to provide treatment in a manner which is beneficial to the clients.

(d) It is the intent of the Legislature:

1. To articulate the existing legal and human rights of persons with developmental disabilities so that they may be exercised and protected. Persons with developmental disabilities shall have all the rights enjoyed by citizens of the state and the United States.

2. To provide a mechanism for the identification, evaluation, and treatment of persons with developmental disabilities.

3. To divert those individuals from institutional commitment who, by virtue of comprehensive assessment, can be placed in less costly, more effective community environments and programs.

4. To fund improvements in the program in accordance with the availability of state resources and yearly priorities determined by the Legislature.

5. To ensure that persons with developmental disabilities receive treatment and habilitation which fosters the developmental potential of the individual.

6. To provide programs for the proper habilitation and treatment of persons with developmental disabilities which shall include, but not be limited to, comprehensive medical/dental care, education, recreation, specialized therapies, training, social services, transportation, guardianship, family care programs, day habilitation services, and habilitative and rehabilitative services suited to the needs of the individual regardless of age, degree of disability, or handicapping condition. It is the intent of the Legislature that no person with developmental disabilities shall be deprived of these enumerated services by reason of inability to pay.

7. To fully effectuate the principles of self-determination through the establishment of community services for persons with developmental disabilities as a viable and practical alternative to institutional care at each stage of individual life development and to promote opportunities for community inclusion. If care in a residential facility becomes necessary, it shall be in the least restrictive setting.

8. To minimize and achieve an ongoing reduction in the use of restraint and seclusion in facilities and programs serving persons with developmental disabilities.

(e) It is the clear, unequivocal intent of this act to guarantee individual dignity, liberty, pursuit of happiness, and protection of the civil and legal rights of persons with developmental disabilities.

(3) RIGHTS OF ALL PERSONS WITH DEVELOPMENTAL DISABILITIES.--The rights described in this subsection shall apply to all persons with developmental disabilities, whether or not such persons are clients of the agency.

(a) Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from sexual abuse in residential facilities.

(b) Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.

(c) Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.

(d) Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.

(e) Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.

(f) Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.

(g) Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.

(h) Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the provisions of s. 393.12(2)(a) or chapter 744.

(i) No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.

(j) No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.

(4) CLIENT RIGHTS.--For purposes of this subsection, the term "client," as defined in s. 393.063, shall also include any person served in a facility licensed under s. 393.067.

(a) Clients shall have an unrestricted right to communication: 1. Each client is allowed to receive, send, and mail sealed, unopened correspondence. A client's incoming or outgoing correspondence may not be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable examination of such mail and regulate the disposition of such items or substances.

2. Clients in residential facilities shall be afforded reasonable opportunities for telephone communication, to make and receive confidential calls, unless there is reason to believe that the content of the telephone communication may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable observation and monitoring to the telephone communication.

3. Clients have an unrestricted right to visitation subject to reasonable rules of the facility. However, this provision may not be construed to permit infringement upon other clients' rights to privacy.

(b) Each client has the right to the possession and use of his or her own clothing and personal effects, except in those specific instances where the use of some of these items as reinforcers is essential for training the client as part of an appropriately approved behavioral program. The chief administrator of the facility may take temporary custody of such effects when it is essential to do so for medical or safety reasons. Custody of such personal effects shall be promptly recorded in the client's record, and a receipt for such effects shall be immediately given to the client, if competent, or the client's parent or legal guardian.

1. All money belonging to a client held by the agency shall be held in compliance with s. 402.17(2).

2. All interest on money received and held for the personal use and benefit of a client shall be the property of that client and may not accrue to the general welfare of all clients or be used to defray the cost of residential care. Interest so accrued shall be used or conserved for the personal use or benefit of the individual client as provided in s. 402.17(2).

3. Upon the discharge or death of a client, a final accounting shall be made of all personal effects and money belonging to the client held by the agency. All personal effects and money, including interest, shall be promptly turned over to the client or his or her heirs.

(c) Each client shall receive prompt and appropriate medical treatment and care for physical and mental ailments and for the prevention of any illness or disability. Medical treatment shall be consistent with the accepted standards of medical practice in the community.

1. Medication shall be administered only at the written order of a physician. Medication shall not be used as punishment, for the convenience of staff, as a substitute for implementation of an individual or family support plan or behavior analysis services, or in unnecessary or excessive quantities.

2. Daily notation of medication received by each client in a residential facility shall be kept in the client's record.

3. Periodically, but no less frequently than every 6 months, the drug regimen of each client in a residential facility shall be reviewed by the attending physician or other appropriate monitoring body, consistent with appropriate standards of medical practice. All prescriptions shall have a termination date.

4. When pharmacy services are provided at any residential facility, such services shall be directed or supervised by a professionally competent pharmacist licensed according to the provisions of chapter 465.

5. Pharmacy services shall be delivered in accordance with the provisions of chapter 465. 6. Prior to instituting a plan of experimental medical treatment or carrying out any necessary surgical procedure, express and informed consent shall be obtained from the client, if competent, or the client's parent or legal guardian. Information upon which the client shall make necessary treatment and surgery decisions shall include, but not be limited to:

a. The nature and consequences of such procedures. b. The risks, benefits, and purposes of such procedures. c. Alternate procedures available. 7. When the parent or legal guardian of the client is unknown or unlocatable and the physician is unwilling to perform surgery based solely on the client's consent, a court of competent jurisdiction shall hold a hearing to determine the appropriateness of the surgical procedure. The client shall be physically present, unless the client's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the appropriateness of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the appropriateness of such procedures. The express and informed consent of a person described in subparagraph 6. may be withdrawn at any time, with or without cause, prior to treatment or surgery.

8. The absence of express and informed consent notwithstanding, a licensed and qualified physician may render emergency medical care or treatment to any client who has been injured or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of

medical certainty, delay in initiation of emergency medical care or treatment would endanger the health of the client.

(d) Each client shall have access to individual storage space for his or her private use. (e) Each client shall be provided with appropriate physical exercise as prescribed in the client's individual or family support plan. Indoor and outdoor facilities and equipment for such physical exercise shall be provided.

(f) Each client shall receive humane discipline. (g) A client may not be subjected to a treatment program to eliminate problematic or unusual behaviors without first being examined by a physician who in his or her best judgment determines that such behaviors are not organically caused.

1. Treatment programs involving the use of noxious or painful stimuli are prohibited. 2. All alleged violations of this paragraph shall be reported immediately to the chief administrator of the facility and the agency. A thorough investigation of each incident shall be conducted and a written report of the finding and results of the investigation shall be submitted to the chief administrator of the facility and the agency within 24 hours after the occurrence or discovery of the incident.

3. The agency shall adopt by rule a system for the oversight of behavioral programs. The system shall establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavioral programs involving clients. The system shall ensure statewide and local review by committees of professionals certified as behavior analysts pursuant to s. 393.17. No behavioral program shall be implemented unless reviewed according to the rules established by the agency under this section.

(h) Clients shall have the right to be free from the unnecessary use of restraint or seclusion. Restraints shall be employed only in emergencies or to protect the client or others from imminent injury. Restraints may not be employed as punishment, for the convenience of staff, or as a substitute for a support plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort.

1. Daily reports on the employment of restraint or seclusion shall be made to the administrator of the facility or program licensed under this chapter, and a monthly compilation of such reports shall be relayed to the agency's local area office. The monthly reports shall summarize all such cases of restraints, the type used, the duration of usage, and the reasons therefor. The area offices shall submit monthly summaries of these reports to the agency's central office.

2. The agency shall adopt by rule standards and procedures relating to the use of restraint and seclusion. Such rules must be consistent with recognized best practices; prohibit inherently dangerous restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of clients and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion, including individualized plans for the use of restraints or seclusion in emergency situations; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; establish requirements for facility data collection and reporting relating to the use of restraint and seclusion; and

establish procedures relating to the documentation of the use of restraint or seclusion in the client's facility or program record. A copy of the rules adopted under this subparagraph shall be given to the client, parent, guardian or guardian advocate, and all staff members of facilities and programs licensed under this chapter and made a part of all staff preservice and inservice training programs.

(i) Each client shall have a central record. The central record shall be established by the agency at the time that an individual is determined eligible for services, shall be maintained by the client's support coordinator, and must contain information pertaining to admission, diagnosis and treatment history, present condition, and such other information as may be required. The central record is the property of the agency.

1. Unless waived by the client, if competent, or the client's parent or legal guardian if the client is incompetent, the ~~client~~'s central record shall be confidential and exempt from the provisions of s. 119.07(1), and no part of it shall be released except:

a. The record may be released to physicians, attorneys, and government agencies having need of the record to aid the client, as designated by the client, if competent, or the client's parent or legal guardian, if the client is incompetent.

b. The record shall be produced in response to a subpoena or released to persons authorized by order of court, excluding matters privileged by other provisions of law.

c. The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility where the client resides, or an employee of the agency when the administrator of the facility or the director of the agency deems it necessary for the treatment of the client, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

d. Information from the records may be used for statistical and research purposes if the information is abstracted in such a way to protect the identity of individuals.

2. The client, if competent, or the client's parent or legal guardian if the client is incompetent, shall be supplied with a copy of the client's central record upon request.

(j) Each client residing in a residential facility who is eligible to vote in public elections according to the laws of the state has the right to vote. Facilities operators shall arrange the means to exercise the client's right to vote.

(5) LIABILITY FOR VIOLATIONS.--Any person who violates or abuses any rights or privileges of persons with developmental disabilities provided by this chapter is liable for damages as determined by law. Any person who acts in good faith compliance with the provisions of this chapter is immune from civil or criminal liability for actions in connection with evaluation, admission, habilitative programming, education, treatment, or discharge of a client. However, this section does not relieve any person from liability if the person is guilty of negligence, misfeasance, nonfeasance, or malfeasance.

(6) NOTICE OF RIGHTS.--Each person with developmental disabilities, if competent, or parent or legal guardian of such person if the person is incompetent, shall promptly receive from the agency or the Department of Education a written copy of this act. Each person with developmental disabilities able to comprehend shall be promptly informed, in the language or other mode of communication which such person understands, of the above legal rights of persons with developmental disabilities.

(7) RESIDENT GOVERNMENT.--Each residential facility providing services to clients who are desirous and capable of participating shall initiate and develop a program of resident government to hear the views and represent the interests of all clients served by the facility. The resident government shall be composed of residents elected by other residents, staff advisers skilled in the administration of community organizations, and, at the option of the resident government, representatives of advocacy groups for persons with developmental disabilities from the community.