KPIC ADDED CHOICE NON-DISCLOSURE NOTICE

Effective / Expiration Date of Notice: Click or tap to enter a date.	
☐ **NEW Non-Disclosure Notice**	☐ **WITHDRAWL/END of Non-Disclosure Notice**

NOTICE OF NON-DISCLOSURE OF MINOR-INITIATED MENTAL HEALTH CARE TO HEALTH PLAN

Kaiser Contact: KPIC Claims **Fax #**: (972) 767-6866

Minor's Name: _____
(Last name) (First Name) (Middle Initial)

Minor's Date of Birth: _____ **Minor's Kaiser Permanente Medical Record Number:** ____

Mother's Name: _____
or Legal Guardian (Last name) (First Name) (Middle Initial)

Father's Name: _____
or Legal Guardian (Last name) (First Name) (Middle Initial)

Pursuant to §577-29, HRS, minors, 14 years of age or older, may consent to outpatient mental health services without parental or legal guardian consent, knowledge or participation, after consulting with a licensed mental health professional and there is agreement on confidentiality for minor initiated services.

☐ I am hereby notifying the minor's health plan that the above named minor received mental health counseling from a licensed mental health professional which included a discussion on confidentiality, and agreement that the minor's mental health services should not be disclosed to the minor's parents/legal guardian for the period of time specified in this Notice .

☐ I am hereby notifying the minor's health plan of the agreement on confidentiality and that the minor's self-initiated mental health services should not be disclosed to the minor's parent(s)/legal guardian through the health plan's explanation of benefits or by any other means. Non-disclosure is temporary and begins and ends according to the effective and expiration dates in this Notice with the minor. Should this Non-Disclosure Notice be withdrawn, I will notify the health plan with an updated Notice.

Licensed Mental Health Professional's Signature <u>REQUIRED</u>:

Signature:_____ Date: _____

Printed name: _____

Agency or name of business: _____

Phone number: _____ NPI #: _____