

Informed Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual

Signature _____ Date _____

Relationship to Patient (if applicable): _____

Patient Care Communication Form

Physician's Name _____ Telephone Number _____

Address _____

Dear Doctor _____

Your patient, _____ was recently referred by _____

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: _____	Date of Next Appointment: _____
Diagnoses and/or presenting problems: _____	

Treatment Recommendations: _____	

Medications: _____	

Please call if further information would be helpful

Clinician's Printed Name _____

Address _____

Address _____

Telephone Number _____

Sincerely,

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits 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.

AUTHORIZATION

I, _____ hereby authorize _____
Print Patient's Name *Print Treating Clinician's Name*

- Please Check One:
- To release any applicable mental health information to my primary care physician (PCP) named above
 - To release any applicable substance abuse information to my PCP named above
 - To release only medical information to my PCP named above
 - Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment

Print Name of Patient or Guardian _____ ID Number _____ Date of Birth _____

Signature of Patient or Guardian _____ Date _____