

AREA MENTAL HEALTH CENTER
REQUEST AND CONSENT FOR TREATMENT
FOR MINOR CHILD OR REPRESENTED ADULT

Name of Person Accompanying Client: _____

I am the Natural or Adoptive Parent Legal Guardian or Durable Power of Attorney for:

Client Name: _____

Client Address: _____

Client Date of Birth: ____/____/____ Client Social Security Number: _____

I understand that by signing this request and consent for initial assessment and treatment that I am agreeing to allow the above named client to participate in a mental health intake assessment at the Area Mental Health Center. The purpose of this assessment is to evaluate mental health needs and to develop specific assessment recommendations related to concerns that have brought this client to the Center.

I understand that the initial assessment will be conducted by an Area Mental Health Center master level therapist. The assessment will consist of interviews of the above named client, and possibly of me. Psychological testing may be recommended to more thoroughly evaluate his/her needs. Some mental disorders can have medical or biological origins and may require a consultation with a physician.

I understand that the practitioner may need to discuss the case in a confidential manner with a professional treatment team and/or supervisor for the purpose of providing quality service. I am aware that additional professional staff may be asked to participate in the evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are referenced in the Client Rights and Responsibilities Brochure of which I have been given a copy. **By signing this form I am also acknowledging that I have received a copy of the Client Rights and Responsibilities Brochure and that I have received AMHC's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).**

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the assessment is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with the practitioner the results of the assessment, the nature of the condition, and any treatment, including alternatives to these recommendations.

I do hereby state and declare that I have the legal right and authority to consent to the assessment and treatment by Area Mental Health Center of the above-named client and that no divorce decree, revocation or court order has been issued which limits, restricts or denies my right to so consent. If I am divorced from the natural or adoptive parent of the above minor child, I understand that the other natural or adoptive parent will be notified of this request and consent for assessment and treatment, and will be entitled to information concerning such assessment and treatment upon proper request. *

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

Signed _____ Date ____/____/____
Parent, Legal Guardian or Durable Power of Attorney

Witness _____ Date ____/____/____

* If divorced – Current name and address of other natural or adoptive parent:
