CLEAR MINDS
Family & Mental Health

Informed Consent to Mental Health Treatment

At my own discretion I am requesting treatment at Clear Minds Family & Mental Health Services. I know that my treatment may consist of Pharmacotherapy and or psychotherapy. I will be educated on the benefits and potential side effects or reactions that may result from any prescribed medication. I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I do withdraw from treatment,I have the right to have a referral to another practitioner for alternative treatment. I agree to allow Clear Minds Family & Mental Health Services to make this document a permanent part of my patient record. Finally, I understand and will expect that all papers and documents concerning my treatment at Clear Minds Family & Mental Health Services will be kept confidential. No information concerning my treatment can be released without my specific written consent except as required by law or in a situation deemed potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others, or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

_____

Patient's Name (printed)

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Signed Signature of Witness (CMF&MHS Staff Member) Date Signed