FOUR COUNTY MENTAL HEALTH CENTER, INC.

PERMISSION FOR ASSESSMENT & TREATMENT

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in a mental health assessment at Four County Mental Health Center. The purpose of the assessment is to determine my current mental health needs and to develop treatment recommendations.

The assessment will consist of interviews, but I may also be asked to participate in psychological testing to more thoroughly evaluate my needs. I may also be asked to see additional professional staff who may participate in my evaluation and treatment.

I understand that my service provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing quality services to me. I understand that these discussions will be kept confidential unless I authorize that the information be released or unless allowed or required by law.

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

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

I acknowledge having received a copy of the Patient Rights and Responsibilities brochure, a copy of Four County's agency brochure that outlines available services, and a copy of Four County's Notice of Information Practices (as mandated by HIPAA regulations).

If medications should be prescribed or medical laboratory tests required as a part of my treatment, I hereby give my consent to release my name to the pharmacy (or indigent program) that I obtain medications from to assist in filling and managing prescriptions for me. I also give my consent to release my name and my diagnosis (if necessary) for the purpose of requesting laboratory tests and obtaining results that may be needed as a part of my treatment. This authorization for release of information will automatically expire upon close of my case at Four County Mental Health Center. I understand that I can cancel this release of information at any time by giving written notification. Permission is hereby given to Four County Mental Health Center, Inc. to provide assessment and treatment.

Patient Name (Please Print)	MRN

Patient / Parent Signature	Date	Staff Member Signature	Date