

CLIENT CONSENT TO TREATMENT & TO RELEASE OF INFORMATION

CONSENT TO TREATMENT: We cannot provide consultation or treatment without your written consent.

I hereby consent to the rendering of care and service by Comprehensive Psychiatric Associates and its clinical staff for myself or for the client named below.

CONSENT TO RELEASE OF INFORMATION: We routinely ask for written consent for the release of clinical information to the three parties specified below. However, you are not required to consent to any release of information whatsoever. If you prefer that we not release information to any of the three parties listed below, you may simply cross out that part of this form, or specify any restrictions on the blank lines below. If you prefer that we not release information to your insurance company, we will require full payment of all charges at the time of the visit. By signing this consent, you are giving us permission to release information only as specified below. If we feel that it would be beneficial to release information to any other party, we will discuss this with you and obtain your written consent prior to releasing information.

I hereby authorize Comprehensive Psychiatric Associates and any Professional Staff Member providing services within Comprehensive Psychiatric Associates to release confidential information regarding evaluation and treatment of myself or the client named below to the following:

1. **To any insurance company or other entity responsible for payment** for mental health services for myself or for the client named below
2. **To other employees and staff of Comprehensive Psychiatric Associates**, for the purpose of providing care and treatment or of obtaining payment or authorization for payment from third-party payers.
3. **To the primary care physician** of the client (or the physician who referred the client for services if other than the primary care physician).

I request that release of clinical information or clinical records be restricted as follows:

By signing this form, I am not giving permission for any disclosure of information other than as specified above. I understand that this consent is non-revocable after the release of information by Comprehensive Psychiatric Associates. I understand that I need not consent to the release of information in order to obtain services, and I do so voluntarily. I understand that the clinical information or clinical records referred to herein may include, but are not limited to, information regarding evaluation or treatment of alcohol or drug abuse and mental illness. I understand that such information may be protected by Federal Regulation 42 CFT, Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records", which prohibits further disclosure without my written consent.

I have read the above and affirm that everything in this document that was not clear to me has been explained to my satisfaction.

Signature of Client

Name of Client, Printed

Signature of Parent or Legal Guardian

Name of Parent or Legal Guardian, Printed

Relationship to Patient: father mother other _____
(Parent only may sign for patient 15 years old or under. Patient and parent must sign for patient 16 or 17 years old.)

Signature of Witness

Date of Signatures