Consent to Service Form

CLIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received [Agency Name] Notice of Privacy Practices. I understand that [Agency Name] can use my Protected Health Information for Treatment, Payment and Operations.

Client Signature_____ **Date** _____/_____/_____ **Time**_____

Printed Name_____

If required, signature of Parent,
Guardian or Legal Representative _____ Date _____/_____/_____ Time_____

Printed Name_____ Relationship:_____

Witness Signature_____ **Date** _____/_____/_____ **Time**_____

CONSENT TO SERVICE

I, _____, birth date _____/_____/_____, voluntarily consent to service as recommended and fully explained to me by staff of [Agency Name] and understand that I am free to withdraw my consent and discontinue service at any time. I agree that my withdrawal of consent is effective upon receipt of such notification in writing by [Agency Name] staff.

I have received and reviewed with [Agency Name] staff the [Agency Name] Program Policies Manual. I understand and agree to comply with the [Agency Name] Program Policies.

I understand that I may participate in the development of my service plan.

_____ _____/_____/_____
Service Participant Signature Date

_____ _____/_____/_____
[Agency Name] Staff Signature Date

CONSENT TO USE E-MAIL

I, _____ have read and understand the policy on consent to use e-mail as a means of communicating with [Agency Name] staff.

_____ _____/_____/_____
Service Participant Signature Date

_____ _____/_____/_____
[Agency Name] Staff Signature Date

Please give one copy to the client and forward the original to the Health Information Management department for placement in the client's medical record.