CHART # _____

DOB: _____

AMERICAN INDIAN HEALTH SERVICE OF CHICAGO, INC

BEHAVIORAL HEALTH

CONSENT TO TREATMENT AND CLIENT INFORMATION FORM

1. I, _____, knowing that I want counseling services for myself and/or my child, voluntarily participate in therapy as agreed upon by myself and a mental health professional. A treatment plan will be developed and written with me, and my goals will be reviewed every 3 months. My consent to receive therapy may be revoked at any time.

2. The American Indian Health Service of Chicago, Inc (AIHSC) maintains its records as regulated by the State of Illinois Mental Health and Developmental Disabilities Code. Other than authorized AIHSC staff, no one may have access to your record unless you sign a release of information form. Only staff permanently or temporarily assigned to a position as Behavioral Health Director, physician, or nurse practitioner may also review information in your record on a need-to-know basis, and only with authorization from the mental health professional.

3. Confidentiality may be broken under the following conditions:
   1.) You are in imminent danger of harming yourself or someone else
   2.) You have reported information about physical or sexual abuse or neglect of a child
   3.) You have information about abuse, neglect or financial exploitation of an adult 60 or older and people with disabilities age 18-59 living in your community.
   4.) Your mental health records have been subpoenaed. Should this occur, you will be informed if possible and no more information than necessary will be disclosed.

4. AIHSC maintains records and statistics for its own organizational planning and operation. Staff may make presentations or conduct research. If this happens, your counselor/therapist must change or conceal any personal identifying information such as names, places, situations or other identifying information so that your identity cannot be known.

5. By signing below, you agree that you wish to seek services from a counselor/therapist at the AIHSC and that you understand the policy regarding confidentiality. The patient rights and responsibilities sheet is posted in the office next to the door for your review.

Client (12 years or older): _____ Date: _____

Guardian/ Parent's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Note: Client unable to give consent for the following reason: _____
Consent for therapy/counseling withdrawn on: ____ / ____ / ____
Reason: _____