MH 500
Revised 02/11/11

CONSENT FOR SERVICES

The undersigned client* or responsible adult** consents to and authorizes mental health services by:

_____
Name of Facility and/or Program

These services may include psychological testing, psychotherapy/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at a different location, services provide within the Los Angeles County mental health system will be coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has a right to be informed of and participate in the selection of any of the above services provided.
2. He/she has a right to receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
3. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or withdraw this consent at any time.
4. All personnel of the agency, as a condition of their employment, annually sign an oath of confidentiality which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures.
5. Any information disclosed to staff which is determined by them to be important to care, will be recorded in the clinical record to ensure treatment staff have available to them the most complete information about the client when deciding on treatment appropriate to the client's needs and for quality of care.
6. All client names are entered into a computer-based Information System that identifies the program(s) that is/are providing services to the client. This information is available without client authorization to any workforce member of the Department's directly-operated or contract service agency system.
7. Information from a client's clinical record relative to service delivery needs may be shared within this agency and within the Los Angeles County mental health system (directly-operated and contract agencies) without obtaining the authorization of the client.

_____ _____
Signature of Client* Date

_____ _____ _____
Signature of Responsible Adult** Relationship to Client Date

_____ _____
Signature of Witness/Interpreter *** Date

This Consent was interpreted in _____ for the client and/or responsible adult.
If a translated version of this Consent was signed by the client and/or responsible adult, the translated version must be attached to the English version.

Signator ☐ was given ☐ declined a copy of this Consent on _____ by _____.
Date Initials

This section must be completed by Staff if signed by Minor or if there is no signature by client and/or responsible adult.

☐ Client is willing to accept services, but unwilling to sign this Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client between the ages of 12-18 signing above without parental/guardian consent.

_____ _____
Signature of Staff Date

* A minor client receiving services under his/her own signature must have the signed Consent of Minor form on file in the clinical record.
** Responsible Adult = Guardian, Conservator, or Parent of minor when required.
*** Witness/Interpreter = Person who either witnessed the signing of the form (may be staff or other person) or the person who interpreted this form into another language for the client (must include the language it was interpreted into).

Name: _____ **IS#:** _____
Agency: _____ **Provider #:** _____
Los Angeles County – Department of Mental Health

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