



Behavioral Health and Psychiatric Services

Informed Consent to Treatment Form

At my own discretion, I am requesting treatment at the CHI St. Joseph Children's Health Behavioral Health Center. I know that my treatment may consist of psychiatric care, psychotherapy, or a combination of psychotherapy and psychiatric care.

I will be educated to the benefits and risks of the treatment I receive, including potential side effects or reactions that may result from any prescribed medication.

I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I decide to withdraw from treatment, I have the right to have a referral to another practitioner for alternative treatment.

I agree to allow CHI St. Joseph Children's Health to make this document a permanent part of my patient record.

Finally, I understand and will expect that all papers and documents concerning my treatment at the CHI St. Joseph Children's Health Behavioral Health Center will be kept confidential. No information concerning my treatment can be released without my specific written authorization except as required by law or in a situation deemed potentially life-threatening.

By law, licensed providers are mandated or permitted to report or warn others of information that, based on their reasonable professional judgment, constitutes a threat of serious harm to self or others, or indicates child or elder abuse or neglect. You have my authorization and consent, without reservation, to release any such information about me or the patient for whom I serve as personal representative (parent or guardian) without the need for further written approval.

Acknowledged & Agreed:

Patient Name (please print): _____

Patient Signature: _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

(Parent/Guardian Signature is required for all patients under the age of 14.)

CHI St. Joseph Children's Health Witness: _____

Date: _____