

CONSENT TO TREATMENT FORM

I authorize _____ to provide evaluation and treatment
(Provider Name)

services to _____.
(Consumer Name)

I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment.

I understand that this consent will remain valid so long as I am enrolled in Magellan Health Services of Arizona, the Maricopa County Regional Behavioral Health Authority (RBHA), or until I withdraw consent.

I understand that by signing this consent form, I am giving permission to the Arizona Department of Health Services / Division of Behavioral Health Services, all members of my clinical treatment team and Magellan Health Services of Arizona, the RBHA, to access my information and records.

I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

Consumer Name (Print)

Consumer Signature

Date

Parent/Legal Guardian

Date

Staff Member (Witness)

Date