

DOCUMENTATION OF INFORMED CONSENT FOR TREATMENT

By signing this form, I understand that I am giving informed consent to receive evaluation and treatment services from _____ in accordance with the information described below. (provider name)

- *I have provided a medical history that is true and complete to the best of my knowledge.*
- *I have been given information about the diagnosis and the specific proposed treatment.*
- *I have been given information about the intended outcome, nature, and all available procedures involved in the proposed treatment.*
- *I have been informed of any additional risks, including any side effects, of the proposed treatment.*
- *I have been informed of the risks of not proceeding with the proposed treatment.*
- *I have been given information on any alternatives to the proposed treatment including those offering less risk or fewer adverse effects.*
- *I have been given a description of any clinical factors that might require suspension or termination of the proposed treatment.*
- *I understand that any consent given may be withheld or withdrawn in writing or verbally at any time and will be documented in the medical record.*
- *I understand that if consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an immediate risk. In such cases, I understand that treatment may be phased out to avoid any harmful effects.*
- *I understand that all information gathered in the course of treatment is confidential and will not be disclosed without my permission except as allowed by law.*
- *I have been allowed the opportunity to ask questions and to have any questions answered in a satisfactory manner.*

Consumer's Name (Print)

Date

Signature of Consumer (or guardian, custodian or agent if applicable)

Printed name of guardian, custodian or agent if applicable