Community Health Centers, Inc.
110 S Woodland St
Winter Garden, FL 34787
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG

Behavioral Health Informed Consent for Therapy Services

I, the undersigned voluntarily agree to participate in behavioral therapy services. I understand that any information obtained will be held in confidence with the exception of legal requirements for disclosing this information. I understand that I can authorize release of information by completing a written consent form. I have the right to terminate from therapy at any time, without prejudice which would void this consent for therapy services. I understand that I have the opportunity to ask questions about the foregoing to my satisfaction. Counseling is a journey and goals often change and there is no guarantee that the goal will be attained. The more proactive involvement, the more effective counseling will be to you. We will establish goals for your therapy. The members of the treatment team may include LCSW, Case Manager, Psychiatrist or any combination of the three services. Team members may collaborate when necessary for treatment purposes. We encourage any supportive person (friends or family) to be involved in your treatment and you will be expected to sign a release of information in order to disclose any information to this person. By signing below, you agree to work towards the goals in your daily life and to use the counseling sessions to achieve your goals, which will be reviewing periodically.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE AND AGREE TO THESE CONDITIONS

I have discussed with my Behavioral Health Therapist and/or Psychiatrist and had an opportunity to discuss this consent and have my questions or concerns addressed.

_____
Name of Patient

_____
Phone Number Date of Birth of Patient

_____
Print Name of Consenting Person Signature of Consenting Person Date

_____
Print Name of Behavioral Health Provider Signature of Behavioral Health Provider Date

_____
Print Name of Behavioral Health Provider Signature of Behavioral Health Provider Date

Relationship to Patient is:

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Authorized Person