

Clinical Services System

Patient Name: _____ # Exp.: _____

Consent for evaluation and treatment

I hereby certify that, _____ of ____ years old and neighbor of _____ residing in _____, I request an evaluation and be offered treatment under the services of the Mental Health Provider _____ that understand is necessary for my stabilization and well-being.

- I understand that the information provided is confidential, subject to the provision of the Puerto Rico Mental Health Act.

Patient signature, father, mother or legal guardian

Date

Mental Health Provider Signature

Date

To be completed by the therapist I have been oriented from the treatment alternatives available for my condition. (Individual therapy, group, family, support groups, etc.)

- I understand that medicine is not an exact science and I acknowledge that I cannot be offered any guarantee as to the outcome of the treatment to which here I am giving consent.
- For the record that I accept and will comply with the terms of this therapeutic contract, I sign this **Informed Consent** for treatment in outpatient clinical services.
- **I authorize information about my treatment to be shared with another provider, either: Mental Health, Primary Physician, Community Agencies, Family Department, Department of Education for the purpose of coordinating services if necessary.**
- I understand that if me to be admitted to outpatient service voluntarily, I will be able to be discharged at the time I so request.
- In case that the relevant authorities of the clinic establish that for my well-being I must be subject to an involuntary admission to the hospital, a request to the court by my family member or if necessary by the clinic representative will be filed in a timely manner.

Patient signature, father, mother or legal guardian

Date: ____/____/____

day/month/year

Family name or representative: _____ Signature: _____

Provider's Name: _____ Signature: _____

License and title _____ Date: ____/____/____

day/month/year