Revoked: ☐ **Yes Date:**

COMCARE of Sedgwick County
Consent for Treatment, Acknowledgement of Notice of Privacy Practices, Acknowledgement of Client Rights & Responsibilities Information, and Consent To Transport Minors

☐ I consent for treatment/evaluation for myself at COMCARE of Sedgwick County.

☐ I authorize and give consent for _____ to be treated in evaluation, therapy, medication management, case management and/or additional supported services at COMCARE of Sedgwick County.

☐ I authorize and give consent for _____ to be transported by COMCARE employees as part of community based treatment services and in the event of medical and/or other emergencies

I acknowledge that a copy of Sedgwick County's Notice of Privacy Practices has been made available to me with the effective date of April 14, 2003.

I have been given a copy of COMCARE's **Client Rights and Responsibilities** document. I understand that if I have further questions about the information in the **Client Rights and Responsibilities** document I may call my care provider or the Program Manager where I receive services.

Consumer's Signature	Date
Parent/Legal Guardian Signature	Date
Relationship to Client, other than Self	
Witness Signature	Date

Patient Name: , Patient ID#:

Consent for Treatment/Client Rights and Responsibilities/Transportation of Minors/Acknowledgement of Privacy Practices

22.008 Revised 12/03; 06/06

Clear Form