

Revoked: Yes Date: _____



**COMCARE of Sedgwick County
Consent for Treatment, Acknowledgement of Notice of Privacy Practices,
Acknowledgement of Patient 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 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 verbal explanation and copy of COMCARE's **Client Rights and Responsibilities** document and grievance protocol. I understand that if I have further questions about the information in the **Client Rights and Responsibilities** document, patient privacy or how to file a grievance I may call my care provider or the Program Manager where I receive services.

Patient Signature: _____

Date _____

Parent/Legal Guardian Signature _____

Date _____

Relationship to patient, other than self: _____

Witness Signature: _____

Date _____

Patient Name: _____

DOB: _____

MRN: _____