Riverside County Department of Mental Health

CONSENT TO TREATMENT

I, _____, consent and agree voluntarily to receive psychological services from Riverside County Department of Mental Health. These services may include, but are not limited to, diagnostic assessments; psychological testing; crisis intervention; individual, group, and/or family therapy; and consultations and referrals to other behavioral health professionals.

I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that I am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

_____ _____

Consumer or Legal Representative's Signature Date