Coastal Mental Health Center

AUTHORIZATION FOR TREATMENT

Last Name	First Name	MI	Date

AUTHORIZATION FOR MEDICAL AND/OR THERAPEUTIC TREATMENT AND/OR PSYCHOLOGICAL TESTING AND/OR INITIAL SCREENING ASSESSMENT

I, the undersigned, a patient, hereby authorize the staff members of the COASTALMENTAL HEALTH CENTER to administer such medical, diagnostic and/or therapeutic interventions as considered necessary for my treatment. Recommendations for treatment will be discussed with me by the evaluating staff member as indicated.

I do hereby authorize the treatment team and/or qualified professional to administer such interventions as deemed necessary to assist me in my recovery. I understand that my doctor and/or evaluating counselor, along with the treatment team, will develop treatment goals, methods and objectives appropriate for me, and that they will involve me in the development of my treatment plan to the extent they believe, in their professional opinions, that I am able to participate. My progress will be evaluated at least monthly by the treatment team and/or I will be referred to the appropriate level of treatment to meet my therapeutic needs.

As a patient at the COASTAL MENTAL HEALTH CENTER, I hereby authorize the Professional Staff to administer the necessary treatment and to actively participate in that process.

If during my treatment at COASTAL MENTAL HEALTH CENTER I am diagnosed as having a communicable disease, I understand that according to law, it must be reported to the County Health Department.

Patient/Parent/Legal Guardian Signature	Date

Witness Signature	Date