CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328.

San Mateo County
Behavioral Health and Recovery Services

APPLICATION FOR SERVICES AND CONSENT TO TREATMENT

I, hereby make application for myself, or my minor child, to receive care and treatment voluntarily from San Mateo County Behavioral Health and Recovery Services (BHRS).

I understand that such care and treatment may consist of an evaluation process, mental health services, case management, and, in some instances, medication. If I or my child receive(s) medication, my psychiatrist or my child's psychiatrist may share information with other physicians about the drugs prescribed and may receive their prescribing information

If this application is accepted, BHRS is authorized to administer the treatment/services described above. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against medical advice.

I further understand that I have the continuing right to an explanation of the treatment to be administered, and that I may address complaints about services to the Office of Consumer and Family Affairs, 800-388-5189. I further understand that my records are confidential under Federal and State law, and will not be released to outside individuals or agencies without my expressed written authorization. However, I realize that certain information may be released without my authorization under circumstances described in the BHRS Notice of Privacy Practices.

☐ I have read the above and I agree to accept treatment for myself/my child, and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Clinician Signature Date

☐ Client refuses or is unable to sign but verbally agreed to Behavioral Health Services on the date entered below.

_____ _____
Reason client refuses or is unable to sign Date

Acknowledgement of Receipt of Notice of Privacy Practices

☐ I acknowledge that I have received a copy of San Mateo County Behavioral Health and Recovery Service's NOTICE OF PRIVACY PRACTICES.

_____ _____
Client/Parent or Guardian Signature Date

☐ Client was offered NOTICE OF PRIVACY PRACTICES but refused to accept.

_____ _____
Clinician Signature Date

☐ Client was not offered NOTICE OF PRIVACY PRACTICES, for the following reason:

_____

_____ _____
Clinician Signature Date

Original to Chart; Copy to Client