City and County of San Francisco
Department of Public Health

COMMUNITY BEHAVIORAL HEALTH SERVICES

Name:

BIS#:

RU#:

CONSENT for Community Behavioral Health Services
Mental Health/Drug and Alcohol Treatment Programs
Assisted Outpatient Treatment

Client's Name: ______________________________

I consent to an assessment to be conducted by San Francisco's Community Behavioral Health Services' (CBHS) Assisted Outpatient Treatment (AOT) program.

I understand that, if I consent to treatment, any proposed treatment will be explained to me by my provider, including the risks, benefits, and reasonable alternatives. I understand that I will have an opportunity to ask questions and have my questions answered.

I understand that CBHS programs provide clinical experiences for a variety of behavioral health trainees. I understand that these individuals who are under the direction of the supervising clinical staff, may provide treatment to me.

I understand that my treatment records are confidential and may be disclosed only as outlined in the DPH Summary Notice of Privacy. I understand CBHS providers are mandated to report to the appropriate authorities, as required by state and/or federal laws, when (1) my provider believes that I may hurt myself or someone else, or (2) my provider suspects child, dependent adult, or elder abuse. I understand that the AOT Care Team may be required to inform the court of the outcome of this assessment and provide treatment recommendations.

I have read this consent, received a copy, and accept its conditions. I also understand that I can withdraw my consent and stop receiving services from this program at any time. I have also received a copy of Patients' Rights for my records.

Date: ____________________ **Time:** ___________am/pm

Signature or Mark: ________________________________

If the client is unable to provide his or her full signature and does not have a legal representative, his or her mark must be witness by two people.

Witness 1:______________________________ ______________________________
Signature Print Name and Tittle

Witness 2:______________________________ ______________________________
Signature Print Name and Tittle

In the event of an emergency I would like the following person notified:

Name: ______________________________ **Relationship:** ______________________

Contact Number(s): ______________________