City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

Name

BIS #

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

Client's Name

I consent to treatment services provided by San Francisco's Community Behavioral Health Services (CBHS) at _____.

I understand that any proposed treatment will be explained to me by my (my dependent's) 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 (my dependent).

I understand my health information may be shared via secure network to authorized health care providers/ organizations for the purpose of providing treatment, coordinating care, and for quality improvement. The behavioral health information may include, but is not limited to: care team members, medications, allergies, current and past lab results, immunizations, vital signs, and dates of encounters. This excludes SUD Treatment covered by 42CFR Part 2. I understand that I may opt out at any time.

Aside from authorized health care providers outlined above, I understand that my (my dependent's) 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 (my dependent) may hurt myself (him/herself) or someone else, or (2) my provider suspects child, dependent adult, or elder abuse. 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.

Signature or Signature or Mark:_____
client/parent/conservator/other legal representative

Date:_____ **Time:**_____ **A.M./P.M.**

If signed by someone other than the client, please state your legal relationship to the client:

_____

If a minor is either 1) emancipated, or 2) 12 years old or older and qualifies for services under Family Code section 6924 and/or 6929, he/she may consent to services and sign this form on his/her own behalf.

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

Witness 1: _____ _____
Signature **Print Name & Title**

Witness 2: _____ _____
Signature **Print Name & Title**