Family and Medical Counseling Service Inc. (FMCS)
Consent for Treatment/Services

I, _____, hereby give consent for treatment, which may include services, supports, and/or medications, as explained to me during the intake process.

I understand that my health information may be used or disclosed to carry out treatment, payment, or health care operations as indicated in the Notice of Privacy Practices, which may be reviewed prior to signing consent.

I understand that my health information may be disclosed to correctional institutions or law enforcement officials and other sources as required by law.

I understand that if there are any changes in the Notice I may request a copy of the revised Notice.

I understand that I have a right to request that the treatment provider at FMCS restrict how my health information is used or disclosed to carry out my treatment, payment, or health care operations.

I understand that the treatment provider is not required to agree to the requested restrictions.

I understand that if the treatment provider does agree to a requested restriction, the treatment provider is bound to keep that agreement and cannot change the agreement at a later time.

I understand that I have a right to revoke this consent for treatment in writing, except to the extent that the treatment provider has already taken actions based upon the previously signed consent form.

I understand that this consent must comply with any special provisions of District of Columbia and Federal laws.

I understand that my health information that is protected by federal law 42 CFR Part 2 requires my written consent before further disclosure.

My signature indicates that I understand the terms of this Consent for Treatment form, it has been clearly explained to me, and I agree to treatment. (If the client is under age 18, a signature of a parent or legal representative is required.)

_____ _____

Signature of Client /Patient ***or*** Authorized Representative (Specify) Date

I authorize Family and Medical Counseling Service, Inc. (FMCS) to release any health or other information necessary to process claims for any services I receive. I authorize payment of health benefits for services I receive to Family and Medical Counseling Service, Inc. (FMCS).

_____ _____

Signature of Client /Patient ***or*** Authorized Representative (Specify) Date

Rev. 09/09