Copper Country Mental Health Services

CONSENT FOR SERVICES

NAME: _____ MCO#: _____ DATE: _____

1. The undersigned authorizes Copper Country Mental Health Services (CCMHS) to administer mental health services to _____, a resident of the County of _____, State of Michigan.

2. I certify that I have received (or been offered a copy) of the NorthCare and CCMHS Notice of Privacy Practices and been informed that treatment, coordination of care, and payment information as necessary can be released for these purposes according to State and Federal laws.

3. I certify that I have received a copy of "Your Rights" booklet and been given the name of the Recipient Rights Officer for CCMHS.

4. I certify that any questions that I have regarding this information have been answered.

   If party was unable to read or understand this, an explanation was provided by:

   (Indicate staff person and method) _____

5. I have been informed that this consent can be withdrawn at any time.

This consent expires one year from the date signed or in the event treatment services are discontinued.

_____ _____

Signature of Authorized Party (consumer/guardian/parent) **Date Signed**

Print name of Authorized Party above: _____

☐ Written informed consent was knowingly and freely given.

☐ Consumer verbally consents to service(s) but refuses to sign.

_____ _____

Signature of Witness **Date Signed**