**SERVICE AGREEMENT**

- **Treatment Authorization:**

The undersigned authorizes _____ to administer mental health and/or chemical dependency treatment to the patient named above. I understand that I may revoke this consent at any time during the treatment period. No guarantee or assurance of results has been made to me regarding the treatment.

**Signature**:_____ **Date**:_____.

Self:_____ Spouse:_____ Parent:_____ Guardian:_____.

- **Information Authorization (Primary Care Physician):**

I authorize _____ or decline_____authorization of the release of information to the primary care physician for the purpose of coordinating care.

**Name of PCP**:_____ **Phone**:_____.

**Signature**:_____ **Date**:_____.

- **Consent for use and disclosure of Personal Health Information (PHI):**

I have been given the opportunity to review the Privacy Policy and give consent for the use and disclosure of personal health information to provide treatment, to arrange payment for services, and/or for other health care operations as provided by law. I understand that changes in the policy are possible, and that if there are changes, those changes will be posted in the office for review.

I understand that I may request in writing that disclosure of my PHI be restricted, and that the therapist is not required to agree to my request. If the therapist agrees to the restriction, that agreement will be honored. I understand that I may revoke this consent, except to the extent that information has already been disclosed.

**Signature**:_____ **Date**:_____.

- **Legal Acknowledgments:**

I understand that my therapist may be required by law to release information without my approval to legal authorities if 1.) there is a clear and serious danger of harm to anyone, 2.) a judge requires specific information in a court case, 3.) it is suspected that criminal offense of a child, disabled adult, or elderly abuse or neglect has occurred.

**Signature**:_____ **Date**:_____.

- **Further Legal Acknowledgements:**

In consideration for the therapeutic services provided, neither I nor may an attorney issue any subpoena or in any way direct the attendance of the therapist to appear for deposition, hearing, trial or matter of any nature as it may relate, in anyway, to the patient, patients family, or anyone who may be affected by the services or opinions rendered on behalf of the patient. I expressly authorize the therapist to disregard any required appearances except those issued under lawful authority of a judge of competent jurisdiction.

**Signature:**_____ **Date:**_____