ELMHURST COUNSELING

Consent to Treatment

I _____, hereby give my consent to
(Name of client or guardian of client)

The Midwest Institute & Center for Workplace Innovation to provide direct clinical services as determined by myself and the clinician working for me.

I understand that information shared with my provider will be maintained in files to ensure that I have access to the best possible services. Every effort will be made to keep information confidential and secure. Only authorized individuals will have access to this information and permissions to disclose will be documented.

If I am a parent or guardian, I am voluntarily giving up my rights to review the clinical file by signing this form. By signing this form, I also am giving up my right to knowledge of clinical services provided to the individual for whom I am seeking services.

In signing this form, I acknowledge that my provider is a mandated reporter and is legally required to contact the appropriate authorities in any situations where neglect or danger to self or others is present.

In order to receive the best possible treatment, the Midwest Institute & Center for Workplace Innovation requests permission to coordinate treatment with your Primary Care Physician and other relevant providers.

☐ **Please check if you wish for the Midwest Institute & Center for Workplace Innovation to obtain Release of Information forms to coordinate treatment with other medical providers.**

☐ **Please check if you DO NOT wish for the Midwest Institute & Center for Workplace Innovation to obtain Release of Information forms to coordinate treatment with other medical providers.**

By signing below, I certify that confidentiality and its' limits have been reviewed.

Client Name (please print): _____

Client Signature:_____Date:_____

If you are not the client, please specify your relationship to the client.

Signed:_____ Date:_____

Relationship:_____

Witness:_____ Date:_____