



Behavioral Health Clinic
Consent for Adult other than Legal Guardian Involvement in Treatment

I hereby authorize the Center for Behavioral Health staff to discuss medical information and treatment of the identified client with the individual(s) designated below.

Client Name: _____

Adult Name: _____

Phone: _____

Adult Name: _____

Phone: _____

At any time, I may revoke this consent in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires 6 months from the date of my signature below.

NOTICE TO RECIPIENTS: You are prohibited from disclosing the information to any other party and are required to destroy the information after the stated need has been fulfilled. This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Father Flanagan's Boys' Home, its employees, and its officers are hereby released from any legal liability for disclosure of the above information to the extent indicated and authorized herein.

Print Client Name <small>(If a minor, person authorized to sign for Client)</small>	Signature of Client <small>(If a minor, person authorized to sign for Client)</small>	Relationship to Client	Date
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Boys Town Records: 4801 Sargent Rd NE
Washington DC 20017

Phone Number: 202-650-6361
Fax Number: 202-650-6362