WHITESIDE COUNTY HEALTH DEPARTMENT
BEHAVIORAL HEALTH INFORMED CONSENT

I ____ (Name of client/parent or guardian) hereby acknowledge that the following Whiteside County Health Department behavioral health counseling information, including medication administration, has been explained to me and that I understand and willingly give my consent to be screened, assessed and, if appropriate, provided and/or referred for additional services.

Behavioral health services are offered as part of the Whiteside County Health Department program, the confidentiality of the records maintained by this program is protected by Federal and/or state law and regulations. Confidentiality may be limited by the following conditions:

1. I understand that I must give my written consent to disclose or release information to/from another person or agency when such information is deemed beneficial to my case. An additional consent form will be signed.
2. I understand that incidents or suspicion of physical and/or sexual abuse of a child will be reported by law to the appropriate agency.
3. I understand that incidents of direct threats of harm to self or others may be reported to the appropriate agency or persons.
4. I understand that information may be disclosed as a result of a court order or subpoena.
5. I agree that confidential case information may be disclosed to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
6. Permission is given to see _______________________________________ (minor) for assessment, counseling, medication administration, and/or referral. I understand that if the minor needs medication prescribed or changed, the parent, legal guardian or custodian must be present or available for consult. I understand that I have the right to consultation regarding progress. I agree to cooperate with the counselor/provider in an effort to facilitate services. By my signature below, I certify that I am the parent, legal guardian, or custodian of said minor child.
7. I understand that Whiteside County Health Department behavioral health/counseling services are not available after business hours. For emergencies I agree to call 911 or go to the hospital emergency room if immediate care is needed.
8. I understand that for the purposes of continuity of care, it may be necessary for my behavioral health provider to exchange information with my primary doctor. I understand that I will be notified if such a disclosure is to be made.

By my signature I certify that I understand all of the above information and that my counselor/provider has discussed it with me.

Signature____ Date________________________

Client/Parent or Guardian

Signature____ Date________________________

Counselor/Provider