



City and County of San Francisco
Department of Public Health
 COMMUNITY BEHAVIORAL HEALTH SERVICES

Name: _____
 BIS#: _____
 RU#: _____

**CONSENT for Community Behavioral Health Services
 Mental Health/Drug and Alcohol Treatment Programs**

Client's Name _____

I consent to treatment services provided by San Francisco's Community Behavioral Health Services (CBHS) at _____.

I understand that any proposed treatment will be explained to me by my (my dependent's) provider, including the risks, benefits, and reasonable alternatives. I understand that I will have an opportunity to ask questions and have my questions answered.

I understand that CBHS programs provide clinical experiences for a variety of behavioral health trainees. I understand that these individuals, who are under the direction of the supervising clinical staff, may provide treatment to me (my dependent).

I understand that my (my dependent's) treatment records are confidential and may be disclosed only as outlined in the DPH Summary Notice of Privacy. I understand CBHS providers are mandated to report to the appropriate authorities, as required by state and/or federal laws, when (1) my provider believes that I (my dependent) may hurt myself (him/herself) or someone else, or (2) my provider suspects child, dependent adult, or elder abuse.

I have read this consent, received a copy, and accept its conditions. I also understand that I can withdraw my consent and stop receiving services from this program at any time.

Date: _____ **Time:** _____ A.M./P.M.

Signature or Mark: _____
 client/parent/conservator/other legal representative

If signed by someone other than the client, please state your legal relationship to the client: _____

If a minor is either 1) emancipated, or 2) 12 years old or older and qualifies for services under Family Code section 6924 and/or 6929, he/she may consent to services and sign this form on his/her own behalf.

If the adult client is unable to provide his or her full signature and does not have a legal representative, his or her mark must be witnessed by two people.

Witness: 1. _____
 Signature _____ Print Name & Title _____

Witness: 2. _____
 Signature _____ Print Name & Title _____