Consent to Treatment Form

I authorize_____to provide evaluation and treatment

(Provider Name)

services to_____.

(Consumer Name)

I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment.

I understand that this consent will remain valid so long as I am enrolled in Molina Complete Care, or until I withdraw consent.

I understand that by signing this consent form, I am giving permission to the Arizona Health Care Cost Containment System (AHCCCS), all members of my clinical treatment team, and Molina Complete Care to access my information and records.

I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

Member Name: _____

Member Signature:_____**Date**: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature:_____**Date**: _____

Staff Member (Witness) Signature:_____**Date**: _____