Adult Patient Consent for Mental Health Treatment

Patient Name:

Date of Birth:

Provider Name:

Treatment Description:

I, the undersigned, voluntarily consent to participate in mental health treatment, including assessment, therapy, and other services provided by the above-named provider. I understand that I may withdraw my consent and discontinue treatment at any time.

☐ I have read and understand the information above, and I agree to participate in treatment.

Signature of Patient:

Date: