



# 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 Magellan Complete Care of Arizona, 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 Magellan Complete Care of Arizona 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:** \_\_\_\_\_