Community Mental Health for Central Michigan

# Consent for Medical Services

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| Name: |  | Case Number: |  |

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| --- | --- |
| Date of Birth: |  |

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| I give permission to CMH for Central Michigan staff and/or |  |

staff to authorize the following services that are checked ☑.

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|  | Routine medical and dental services |
| Examples include: Basic First Aid, administration of medication, routine medical and dental care, lab work, evaluations, and transportation. |

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|  | Emergency medical treatment and emergency surgery after every reasonable effort has been made to contact me and I cannot be reached. |
| I understand that any elective surgical procedure or elective non-routine and non-emergency medical procedure will require a separate individualized consent. |

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|  | Payment of appropriate third-party reimbursement benefits to the provider of service. Authorize release to the third-party vendor any information needed to determine these benefits for related services. |

I understand that I may revoke this consent at any time without reprisal.

**This consent expires one year from the date it is signed or upon termination of services.**

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| *Consumer Signature* | *Date* |

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| *Guardian Signature* | *Date* |

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|  |  |  |
| *Witness Signature* | *Date* |