Christian Health Care Center
ESTABLISHED 1911

AUTHORIZATION FOR OUTPATIENT TREATMENT CONSENT FORM

I, _____ authorize the staff of the Christian Health Care Counseling Center to treat and/or counsel _____.

I, _____ authorize the Christian Health Care Counseling Center to call and confirm an appointment, should the need arise. I understand that this is in no way a breach of confidentiality and herby grant permission for the Center to call and leave a message regarding the appointment at the following numbers listed below. The Center will not release any information that is protected under state and federal guidelines. I understand that I can revoke this authorization at any time by notifying the Christian Health Care Counseling Center in writing.
Please use the following numbers of contact:

Home: _____

Cellular:_____

Business: _____

☐ I **DO NOT** authorize CHCCC to contact me to confirm my appointments.

This consent will remain in effect during the time the patient is attending the Christian Health Care Counseling Center.

Patient stated/restated in his/her words, indicating she/he understood, and provided signature acknowledging same.

_____ _____
Patient/Guardian Signature Date/Time

_____ _____
Staff Signature Date/Time