Rae's Playze Adult Day Center

SEEING THROUGH THE EYES OF OTHERS

Consent for Treatment

Consumer Full Name: _____Record Number: _____Medic aid #_____

CONSENT FOR TREATMENT

Initials_____

I here by give Rae's Playze Adult Day Center the consent to deliver treatment that have been outlined in my Individual Service Plan, Person Centered Plan, and/or Application for treatment. Rae's Playze staff is given consent to provide habilitative, behavioral and medical (if applicable and qualified) services.

CONSENT FOR EMERGENCY TREATMENT

Initials_____

In the event of any medical emergency, I authorize Rae's Playze and its employee or other representatives to provide or obtain such medical treatment as may be advised under the circumstances and agree to assume sole responsibility for all charges in such treatment whether billed to me or Rae's Playze.

CONSENT FOR THE RELEASE OF MEDICAL RECORDS

Initials_____

I here by authorize Rae's Playze to release/exchange/obtain information to/from the following agencies, natural supports, and other entities as it applies to the individual served by Rae's Playze.

CONSENT FOR TRANSPORTATION

Initials_____

I consent to have Rae's Playze Adult Day Health Care Center staff transport for the purpose of attending Day Support Services, special events, or field trips.

CONSENT FOR PUBLICITY

Initials_____

I consent for Rae's Playze Adult Day Health Care Center to use personal images for the purpose of websites and/or literature to help promote the services of Rae's Playze Adult Day Health Care Center.

CONSENT FOR DISCLOSURE OR SUBSTANCE ABUSE

Initials_____

I hereby give Rae'sPlayze Adult Day Health Care Center the authorization to receive information from my PrimaryCare Physician and/or any medical professional in regards to my history with substance abuse for the purpose of full disclosure and to protect the staff and clients of Rae's Playze Adult Day Health Care Center.

CONSENT FOR THE DISCLOSRE OF HUMAN IMMUNODEFICIENCY VIRUS

Initials_____

I hereby give Rae's Playze Adult Day Health Care Center the authorization to receive information from my Primary Care Physician and/or any medical professional in regards to my history with HIV for the purpose of full disclosure and to protect the staff and clients of Rae's Playze Adult Day Health Care Center. This consent will be valid one year for the date of signature.

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Guardian/Legal Responsible Person **Date**