Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials Date

**Minor Consent for Services**

**Confidential Services:**

Under Michigan law, I understand that minors may, without parental consent, receive advice, testing and/or treatment for substance abuse, family planning counseling services;sexually transmitted diseases, and HIV, which are defined as Confidential Services.

I further understand that minors 14 years of age and above can, without parental consent, obtain outpatient mental health services not to exceed 12 visits over four months and not to include any medications. I understand that the counselor treating me may notify my parent or guardian without my permission if someone is hurting me or I am hurting myself or someone else, or if I have a plan to hurt myself or someone else. In those cases, the counselor will try to inform me of their duty to notify my parents/guardian before informing them.

I have read and understand the above information and sign it freely and voluntarily.

**By signing this form, I agree to the following:**

* **I have reviewed and understand the Confidential Services offered by the Alcona Citizens for Health, Inc. (AHC) Child and Adolescent Funded Programs. I understand it is not necessary to renew my consent yearly. I understand I may withdraw my consent for services at any time upon written notice.**
* **I received a copy of the Alcona Citizens for Health, Inc. *Notice of Privacy Practices* brochure.**
* **I understand there will be no charge or billing for this service.**

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| (DATE) |  | (Printed Name and Birth Date) |
|   |   |   | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|    |   |   | (Signature)  |
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|    |   |   | (Witness Signature) |  |