Outpatient Treatment Consent Form

Patient Information

Full Name

Date of Birth

Contact Number

Consent to Outpatient Treatment

I hereby authorize and consent to outpatient treatment, including assessment, diagnosis, and interventions deemed necessary and recommended by my healthcare provider. I acknowledge that I have been informed about the nature, goals, and possible risks or side effects of the outpatient treatment.

Initials (to acknowledge understanding and consent)

Risks, Benefits, and Alternatives

I have been informed about potential benefits and possible risks associated with the outpatient treatment, as well as available alternatives. I understand that I may withdraw my consent and discontinue treatment at any time.

Confidentiality

I understand that my records will be kept confidential, except where disclosure is required by law or permitted by my written permission.

Questions & Additional Notes

Please write any questions or additional information here:

Patient Signature

Date

Guardian Signature (if minor)

Date