GLOBAL HEALTHCARE SERVICES, LLC.
Joint Commission Accredited

COMPREHENSIVE CONSENT FORM

Regarding: _____ Date of Birth: _____

I/We hereby authorize Global Healthcare Services LLC to obtain information from/send information to:

_____
_____
_____
_____

____ Medical information, including immunization records
____ Inpatient and/or outpatient psychological/psychiatric/substance abuse treatment records
____ Academic and educational records, including Achievement testing
____ Other _____communication as necessary _____

I authorize this clinic to speak by telephone with you about the reasons for referral, and relevant history, or diagnoses, and to share other information to assist with the client's treatment and/or evaluation.
This authorization to release information is being made to aid in planning effective evaluation and treatment for this client. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not obligated to release them. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan for the client.

In consideration of this consent, I hereby release the above source of records from any and all liability arising there from. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. Unless expressly revoked earlier, this consent expires upon completion of the current treatment and/or one year from current date.

Signature of Client: _____ Date: _____

Signature of Custodial Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

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