Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-6823 – Dental

CLIENT AFFIRMATION & CONSENT TO TREATMENT

Client Name: ______________________________

Client Affirmation and Consent to Treatment:

Maple Street Clinic/Morgan Street Clinic/Macoupin County Public Health Clinic Site has given me a copy of the Client Rights and Responsibilities Form, which explains my rights as a client. This form details my rights under Chapter 2 of the Mental Health and Developmental Disabilities Code and other applicable rights. It explains confidentiality and potential restrictions of confidentiality.

I understand my rights and give my consent for treatment for myself (or my minor child). I know the risks and costs involved in the treatment process, including the nature of the treatment, possible alternatives treatments, and potential risks and benefits of the treatment.

Client Signature (12 and older): ______________________________

Parent/Guardian Signature: ______________________________

Staff Affirmation:

On ________________ I have a copy of the full Client Rights and Responsibilities Form to:
(date)

______________________________ and/or their parent/guardian: ______________________________.
(client name) *(parent/guardian name)*

An explanation of these rights has been provided in a language and method of communication understood by the client, and I believe the client understood his/her rights.

Staff Signature: ______________________________