



Parsons State Hospital & Training Center
Dual Diagnosis Treatment & Training Services
2601 Gabriel Avenue, PO Box 738
Parsons, KS 67357-0738
Ph: (620) 421-6550 x1695 Fax: (620) 421-3623

CONSENT FOR EVALUATION AND TREATMENT

I/we grant permission for Parsons State Hospital and Training Center / Dual Diagnosis Treatment & Training Services (DDT&TS) team to complete a full evaluation of my son/daughter/ward/self, _____, which may include any or all of the following: observe; share information; review records, make behavior support recommendations; and, if necessary, pilot various behavior support strategies.

I realize when behavior supports are initiated there exists the possibility of a temporary (i.e., few days or weeks) of increased or worsening of behaviors for which my son/daughter/ward was referred. I understand that all of the information regarding the evaluation will remain confidential.

This consent will remain in effect until it is expressly revoked in writing or until one year from the date signed, whichever occurs first.

Client/Consumer Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.