Informed Consent

Client's Name: _____

Social Security Number: _____ **Date of Birth:** _____

Southeast Kansas Mental Health Center and Ashley Clinic have merged as one company to strive towards whole person care for all individuals served.

Your treatment team now includes your provider with Southeast Kansas Mental Health Center and Ashley Clinic therefore, information can be shared with provider on your treatment team.

_____ _____

Signature of the Patient: **Date of Signature:**

_____ _____ _____

Signature of personal representative: **Relationship:** **Date of Signature:**

_____ _____

Witness Signature: **Date of signature:**