Corvallis SCHOOL DISTRICT

Mental Health and Wellness Program
Consent for Treatment

Student Name	Student DOB

I authorize Corvallis School District 509J mental health and wellness program to provide evaluation and treatment services.

I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment. If I fail to follow through with treatment recommendations or attend meetings I may be discontinued from services.

Furthermore, my provider explained the benefits and risks of services; adverse effects from services; risks of not receiving treatment; and alternative treatment options. I understand that this consent will remain valid as long as I am a client of the mental health and wellness program or until I withdraw consent. I understand that by signing this consent form, I am giving permission to all members of my clinical treatment team to access my information and records as well as the Oregon Health Authority.

I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

Student Signature (if minor and older than 14)	Date SIgned

Parent/Guardian Signature Date (required for students under age 14	Date Signed