SENDAN CENTER
excellence in child & adolescent mental and behavioral health

4201 Meridian Street, Suite 113
Bellingham, WA 98226
www.SendanCenter.com
p 360.305.3275
f 360.734.5503

Consent for Treatment

By my signature below I give my consent for the patient named below to receive mental and behavioral health (and related services, as appropriate, e.g. speech language or learning services) assessment, evaluation and/or treatment at Sendan Center.

Patient Printed Legal Name (first and last)

Parent or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient | Relationship (Parent, legal guardian, personal representative)

Receipt of Sendan HIPAA Notice of Privacy Practices

The Sendan Center HIPAA Notice of Privacy Practices describes in detail your rights and our responsibilities regarding how your health information may be used and disclosed, and how you can access your information. It is available on our website and in hard copy at our office.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Printed Name

Parent or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient | Relationship (Parent, legal guardian, personal representative)

This form will be retained in the patient's medical record.