Guthrie Mainstream Services
6549 E. University Dr.
Mesa, AZ 85205
Phone: 480.663.8881
Fax: 480.633.7095

ADH/CDH Medical Consent and Authorization

I, _____, certify that I am the _____
(Full name of Legal responsible person) (Relationship to the individual)
of _____, I hereby give consent and authorization to
(Full name of individual)
_____ , the ADH/CDH provider to the following items listed
(Full name of ADH/CDH provider)
below. I consent to the following for a period not to exceed 12 months from the date on my signature.

____	Yes	____	No	Necessary emergency treatment
____	Yes	____	No	Routine medical care
____	Yes	____	No	Routine dental care
____	Yes	____	No	Use of sedation/restraint when prescribed by a physician for medical/dental purposes
____	Yes	____	No	Necessary education, vocational & therapeutic evaluations/assessments with the exception of _____

Release the following information:

____	Yes	____	No	Medical records
____	Yes	____	No	Educational
____	Yes	____	No	Social
____	Yes	____	No	Psychological
____	Yes	____	No	Financial
____	Yes	____	No	Other: _____

The categories where I have checked "No", my signature is required prior to the occurrence of such events or the release of any information.

The above information has been explained to me and I certify that I understand it fully. I also understand that my consent may be withdrawn at any time by my written notification to Guthrie Mainstream Services.

_____ _____
Individual signature Date

_____ _____
Responsible Person Signature Date

_____ _____
ADH/CDH Provider Signature Date

_____ _____
Guthrie Mainstream Services Signature Date