AUTHORIZATION FOR MEDICAL TREATMENT

Name:_______________________________________SS#_________________________________

D.O.B._________________________ Telephone: __________________________________

Street Address:_____________________________City _____________________ ZIP___________

by

Case Management Services, Inc.

A. Assist in Medication Administration
B. Perform Routine First Aid
C. Secure Necessary Medical Services

I understand that this authorization for Medical Treatment may be revoked by the person served and/or their guardian at any time except to the extent the action has already taken place. I understand that if I revoke this authorization I must do so in writing and present my written revocation to my case manager. Unless otherwise revoked, this authorization is valid. Unless directed otherwise by the person served or their guardian, this release authorizes CMS, Inc., to share information with potential Johnson County affiliates (CDDO, SRS), which are bound by established confidentiality guidelines.

I have read the above Authorization Treatment and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

DATE____________Signature of Person Served_______________________________________

DATE____________Signature of Authorized Representative______________________________

Please complete the following section if signed by a parent, guardian or authorized representative

Printed Name of parent, guardian or authorized representative__________________________________

Address/phone number ____

Relationship____