Patient Name:
Date of Birth:

Streamwood Behavioral Healthcare System
Guardianship Acknowledgment and Certification
Consent for Assessment & Medical Screening

I, _____, hereby acknowledge and certify that I am the legal guardian of _____, age _____, and can legally consent to all assessment, evaluation and treatment for above mentioned minor.

I hereby authorize the staff of Streamwood Behavioral Healthcare System to perform an assessment and/or a medical screening. I understand that I have the right to refuse any such assessment and/or medical screening. I understand that all information is confidential unless an authorization for use or release of information is completed. I certify that I have read and fully understand the above consent for assessment and/or medical screening and I agree to absolve Streamwood Behavioral Healthcare System and its staff rendering the treatment (s) from any liability. I agree to produce legal documentation regarding the status of my guardianship within twenty-four hours of assessment, evaluation and/or treatment.

I understand that Streamwood Behavioral Healthcare System utilizes silent video surveillance in patient care areas of the facility for the health and safety of patients, staff and visitors, as well as the general public.

_____ 8/18/2015
Signature of Responsible Party Date

_____ 8/18/2015
Witness Date