CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328.

San Mateo County Health System
Behavioral Health and Recovery Services

PARENT/YOUTH PERMISSION FORM

STUDENT OBSERVATION AT A BEHAVIORAL HEALTH CLINIC

I hereby give permission for my son/daughter, _____ _____ to visit one or more clinics where San Mateo County Behavioral Health and Recovery Services are provided.

I give consent to my child's participation in this experience so that he/she can learn about county behavioral health services. I understand that my child may see mental health clients throughout the community treatment clinic.

It is possible that my child may see someone that he or she knows who is also a client of the county. I understand that this information is private and is not to be shared with others. I will advise my child of the importance of keeping the protected health information of other people confidential.

I know that I should call Kristin Dempsey at 650-372-3214 if I, or my child, have any questions about the purpose of the field trip or about this Permission Form.

_____ _____

Parent or Guardian Signature Date

_____ _____

Youth Signature Date