

I, \_\_\_\_\_, agree to participate in services provided by NWF Health Network (NWFHN) on behalf of:

Myself \_\_\_\_\_  
(Date of Birth)

Minor Child \_\_\_\_\_  
(Print Child's Name) (Date of Birth)

The program/services have been explained to me and I voluntarily consent to the program/services.

I have been informed of the benefits and had the opportunity to discuss risks and alternatives to the planned services.

The services provided may include face-to-face meetings, telephone conversations, and technology-based interactions including video conferencing, email and text exchanges.

I agree to work collaboratively with NWFHN professionals, take an active part in the development of any service plans, and work toward the outlined goals.

This consent for services shall be effective on the date of the signature and unless revoked in writing earlier, shall expire one year from the date of signature for ongoing service provision.

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**SIGN SECTIONS THAT APPLY**

CONSUMER

PARENT/GUARDIAN OF MINOR CHILD

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*