Acknowledgment of Patient Rights

By signing below, I document that my rights as a recipient of services at the program and federal confidentiality requirements have been explained to me, and written material about my rights and confidentiality have been provided.

Client Signature: ________________________________  Date: ________________

Witness Signature to be Signed by Staff: ________________________________

- All treatment at BryLin Behavioral Health Center Outpatient Services is provided on a voluntary basis.
- BryLin does not discriminate on the basis of race, religion, age, sex, handicap, national ancestry, sexual orientation, or economic condition.