DAYMARK RECOVERY SERVICES

Medicaid #: ______________________________________ **MR#:** ______________________________________

Client Name: ______________________________________ **Date of Birth:** ________________________________

CONSUMER RIGHTS AND RESPONSIBILITIES:

I have received *Your Rights and Responsibilities* information that explains consumer rights and responsibilities.

I have also received additional information that explains the consumer grievance process, search and seizure, privacy notice and suspension and expulsion.

I understand that I may ask questions for clarification if I have questions or concerns.

I understand that I may request restriction(s) on how confidential information is used and disclosed, and that in specific situation(s) my request for restriction(s) may not be honored because of the State and Federal laws or other special situations.

I agree to keep all information about other consumers confidential and will not disclose or discuss with any person or agency outside of DAYMARK.

____ _______________________________

Signature of Consumer/Legally Responsible Person Date

____ _______________________________

Print Name of Legally Responsible Person/Relationship to client Signature of Witness

(*required only if signature is an 'X', mark or symbol)*