Consent Follow-Up

I,
Enter Your Name: _____

do hereby give my informed consent to Blooming Cactus Wellness, to allow it to contact me after I am discharged from treatment, for the purpose of my follow-up care and/or research. Your consent will help to evaluate our programs by measuring the long-term benefits we are able to provide to our clients. We thank you for your cooperation in this effort by us. This information will be kept confidential, at the level of in of individual identification and will be shared only with the treatment team members, or the research and data gatherers.

Patient's Primary Phone: _____

I understand that I may revoke this consent at any time in writing to the Blooming Cactus Wellness' office administration.

_____

Print Name

_____ _____

Client Signature **Date**

_____ _____

Parent/ Guardian Signature **Date**