

Stockbridge Munsee Health & Wellness Center

BEHAVIORAL HEALTH

Communicable Disease Information

Client Name: _____ D.O.B.: _____

By signing below, I am confirming I have received information about communicable diseases from my therapist and discussed my risks and potential resources for managing these risks.

The following diseases were discussed and information provided:

- HIV/AIDS
- Tuberculosis
- Sexually Transmitted Diseases
- Hepatitis B and C

Signature of Client (age 18 years or older) or legal representative

Date

Signature of Minor (age 14 years or older)

Date

Relationship to Patient (If signed by legal representative)

Signature of Witness

Date