State of Louisiana
Louisiana Department of Health
Office of Behavioral Health

ACKNOWLEDGMENT OF NOTIFICATION OF RIGHTS

Facility Name:	
Patient Name:	Patient #:

By initialing, you acknowledge written receipt of, and understand the explanation of:

1.) The procedure for requesting release from this facility. _____ (initials)

2.) The availability of counsel. _____ (initials)

3.) Information about the Mental Health Advocacy Service. _____ (initials)

4.) OBH-16 – Rights of Patient as listed in Revised Statute 28:171 _____ (initials)

5.) The rules and regulations applicable to or concerning my conduct while a patient in this treatment facility. _____ (initials)

Patient Signature:	Date:
Patient Address: Street:	

City:	Parish:	State:

Facility Witness Signature:	Date:
Title:	