

St. Clair County Community Mental Health
Request for Voluntary Discharge from Services

Date: _____

To: St. Clair County Community Mental Health

I, _____, am requesting voluntary discharge from all services provided through St. Clair County Community Mental Health, effective immediately.

I understand that by requesting discharge, ALL services including: psychiatry, case management, clinical, and peer support appointments will be terminated upon the processing of this request.

Please remove me from active services and cancel any future scheduled appointments effective immediately unless otherwise required by law or policy.

Individual Served Information:

- Full Name: _____
- Date of Birth: _____
- Individual Served ID: _____
- Phone Number: _____
- Address (Optional): _____

Reason for Request (Optional):

Individual Served Signature: _____

Guardian Signature: _____

Effective Date of Discharge: _____

Staff Name & Program: _____

Staff Signature & Credentials: _____