Psychiatric Associates, P.A.
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CONSENT FOR TREATMENT

I, the undersigned responsible party, do hereby give my consent to

_____, for the treatment of _____
(Provider) (Patient)

_____ _____
(Signature of responsible party) (Date)

_____
(Witness)

RELEASE OF MEDICAL AND PSYCHOLOGICAL INFORMATION

Psychiatric Associates places high emphasis on patients' rights. Many precautions are taken to ensure confidentiality. Patient information will be released only in accordance with our Notice of Privacy Practices or under one of the following circumstances.

1. A release of information is signed by the patient or the patient's legal guardian. The release of information will state to whom the information will be released. The release is valid until written revocation by the patient is given. (Information once released can no longer be protected by Psychiatric Associates.)

2. Psychiatric Associates will release pertinent information to the proper authorities to protect a person's life.

3. Psychiatric Associates will obey court orders issued by a judge.

4. Psychiatric Associates will comply with the Florida law requiring that any evidence of child abuse or elder abuse be reported to the Department of Health and Rehabilitative Services.

I have read and understand the above information.

_____ _____
Patient's Signature Date