CONSENT TO TREATMENT

I, ____, voluntarily consent to Psychiatric
(patient name)
care and routine diagnostic procedures as necessary.

CONFIDENTIALITY: All information between physician and patient is held strictly confidential unless:

1) The patient authorizes release of information with signature;
2) The physician is ordered by a court to release information;
3) The patient presents a physical danger to themselves or others;
4) Child abuse/neglect is suspected. In the two latter cases, we are required by law to inform potential victims and legal authorities, so that protective measures can be taken.

I have read the foregoing, understand its content, and agree to the conditions stipulated herein.

____ ______________________
Patient Signature Date

____
Printed Name