James R. Parks, M.D. PLLC
Child & Adolescent Psychiatry

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General Consent for Treatment/Informed Consent

I authorize my psychiatrist to carry out psychological examinations, treatment, and diagnostic or medical procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement.

General Consent for Treatment (if patient is a child or dependent of beneficiary)

On behalf of the patient, _____ (Please print name), I (the legal guardian or legal representative) legally authorize James R. Parks, M.D. PLLC to deliver mental health care services to the patient as described in the **General Consent for Treatment/Informed Consent** paragraph above.

Patient/Guardian: _____ Date: _____

Physician: _____ Date: _____

Consent to Submit Private Health Information for Insurance Claims

I, _____ (print name) authorize James R. Parks, M.D. PLLC to release any protected health information (PHI) necessary to process insurance claims. I also authorize my insurance carrier to make payments to James R. Parks, M.D. PLLC

Signature of insured/representative: _____ Date: _____

Patient Consent To Release of Information

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment. I authorize that James R. Parks, M.D. PLLC may disclose any information, including drug and alcohol abuse and HIV status, regarding my or my child's treatment for the purposes of continuity of care. I know I have the right to revoke this authorization which must be in writing and given to my provider. This authorization is valid as long as I am treated at James R. Parks, M.D. PLLC or by revoking the authorization.

Patient/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____