Psychology Associates of Brevard

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(321) 751-1925 Fax (321) 751-9261

PATIENT INFORMATION:

Date:_________________________

Name: ____ Sex: ☐ Male ☐ Female

Date of Birth: ____ / ___ / ____

Current Provider: ___________________ Referred to: _______________________

IN HOUSE REFERRAL

Consent for Treatment and Sharing of Treatment Records

I understand and voluntarily agree to participate in the evaluation and/or counseling through the above-named providers. I understand that I will be provided with an explanation of assessment and/or counseling procedures for their purposes.

I also give consent for treatment of medications, if indicated, and understand that a reasonable explanation regarding treatment and medications will be provided.

I give consent to the above-named providers to share confidential information that will assist in my treatment.

I understand that this consent for services may be withdrawn at any time, and that I have the right to refuse to participate in any procedures that may be suggested, as well as the right to withdraw from counseling at any time.

____
Print Patient Name or Authorized Representative

X ____ Date:______________________
Signature of Patient or Authorized Representative