Julia Irwin, MD PC

Psychiatry

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**INFORMED CONSENT, CONFIEDENTIAL DESCRIPTION OF SERVICES**

**Description of services:** it is my understanding that Julia Irwin, MD, PC.,

Donna Bowers, MSPA-C, Nicole Holzer, APRN-CNP and Neneth Phung, MSPA-C

are qualified in Oklahoma to practice medicine. Counseling and medication management involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotion pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for completed sessions.

**Confidentiality:** All services provided, and all information obtained are kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed such as:

1. A “duty to warn” ethic allows a clinician to break confidentiality when danger exists to the patient or client or others.
2. Under exceptional circumstances, the court may subpoena patient or client’s records and may order a clinician to give testimony during a court hearing.
3. Third party payers, such as insurance companies, have a right to review patient or client’s records prior to payment.
4. Delinquent accounts may be turned over to a collection agency.
5. Based on clinical judgment, consultation with another professional with respect to your treatment may be sought.
6. Actual or suspected abuse to children or the elderly must be reported to authorities.

Your signature indicates that you have read and understood the above information concerning confidentiality and that you have read and understood the description of services, and consent is given to provide services to you.

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Signature Date

OTHER USES OF PSYCHIATRIC INFORMATION.

Other uses and disclosures of psychiatric information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose psychiatric information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose psychiatric information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I warrant that I have read all terms and conditions of the Patient Privacy Notice and understand that I will be provided a copy upon request.

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Signature Date