Indianapolis Trauma Therapy Center

Trauma and Attachment Therapy
Psychotherapy, Consultation, Training

AUTHORIZATION TO TREAT

CONSENT FOR TREATMENT:

I/We consent that _____(DOB)_____ may be treated as a client of Indianapolis Trauma Center and its associates.

COORINATION OF TREATMENT:

It is important for all health care providers to work together. As such, we would like your permission to communicate with your primary care physician, psychiatrist and/or therapist. Your consent is valid for one year. You have the right to revoke this authorization, in writing, at any time. A revocation is not valid to the extent that we have acted on reliance on such authorization. If you elect to decline consent, no information will be shared.

____ Indianapolis Trauma Therapy Center may inform my physician(s)/therapist

____ I decline to inform my physician(s)/therapist

Physician/therapist name _____Clinic _____

Address _____ Phone _____

Physician/therapist name _____ Clinic _____

Address _____ Phone _____

EMERGENCIES:

Office Hours are Monday through Thursday 11:30 am – 7:30 pm and Friday 11:30 am – 6:30 pm. If there is an emergency, and you or your child require(s) immediate attention, please call 911, the Gallahue Crisis Line at (317) 621-5700 or the phone number your insurance company indicates for emergency.

Signature_____Date_____

Signature_____Date_____