500 W. Central Rd.
Suite 200
Mount Prospect, IL, 60056

CONSENT FOR COMMUNICATION

This consent must be signed in order for any associate with Ramos & Associates Behavioral Health Clinic to communicate or discuss protected health information about the patient with a guardian or family member. This includes information related to the care or changes to the care a patient has received.

I, _____, consent to all associates of Ramos Behavioral Health Clinic, which may include the attending Psychiatrists, Psychologist, and/or counselors, to discuss healthcare information about my care to the following people:

Name _____ Relationship_____

Phone_____

Name _____ Relationship_____

Phone_____

Name _____ Relationship_____

Phone_____

Additional comments or direction: _____

_____

_____

_____

_____

Signature of

Patient/Guardian _____

Date _____