**North Texas Child Psychiatry, PLLC**

**Shauna Reid, M.D.**

**400 N. Allen Dr. Suite #103**

**Allen, TX 75013**

PH: 972-885-0715

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Informed Consent for Treatment

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Treatment:

I grant permission for Dr. S. Reid to provide mental health services to me. I understand and agree to the conditions of my treatment and prescription of medication.

Confidentiality:

I understand Dr.Reid is committed to the confidentiality of communication with patient. Services provided by Dr.Reid and information I disclose are confidential except as required by state or federal regulation. Personal information I have disclosed may be entered into my clinical records in written form.

Release of Information to Primary Care Physician:

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_I give my permission for Dr. Reid to contact my Primary Care Physician regarding my treatment.

\_\_\_\_\_\_\_\_\_\_I do not wish Dr. Reid to contact my Primary Care Physician regarding my treatment.

\_\_\_\_\_\_\_\_\_\_I do not have a Primary Care Physician.

I have read the above information and understand the consent for treatment.

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Patient or Legal Representative Witness

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Relationship to Legal Representative Date