CONSENT FOR TREATMENT & RELEASE OF INFORMATION

Please Initial (your agreement) after each paragraph:

Patient Name:____________________________________ Date of Birth:____________

I, __________________________ hereby give my consent for Jennifer C. Heath, M.D. to give treatment which may include prescribing medication and or therapy for the above patient. _____ **Initial Here**

RELEASE OF INFORMATION

Patient Name: ____________________________________ Date of Birth: __________

I, _________________________hereby give permission for Jennifer C. Heath, MD to Send, Receive and /or give verbal and/or written information to or from:

_______________________________ I also hereby authorize Jennifer C. Heath, MD
Primary Care Physician
to release information concerning my psychiatric treatment to my insurance companies, other physicians currently treating me or to whom I may be referred for treatment, and/or extended care providers. ____ **Initial Here.**

I UNDERSTAND THAT I MUST CALL TO CANCEL A SCHEDULED APPOINTMENT IN ADVANCE OR I WILL RECEIVE A BILL FOR THE TIME RESERVED FOR ME. Insurance companies will not pay for missed appointments.
______ **Initial Here**

I ALSO UNDERSTAND THAT RECURRENT MISSED APPOINTMENTS OR LATE/FREQUENT CANCELLATIONS CAN RESULT IN MY BEING DISMISSED FROM DR. HEATH'S CLINIC. _ **Initial Here**

____ ______________________

Signature of Patient or Guardian **Date**

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