INTEGRATED PSYCHIATRIC SERVICES
HEALTHY MIND, HEALTHY BODY

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ANNUAL CONSENT/AUTHORIZATIONS

Patient Name: _____ DOB: ____/____/_____

Consent for Treatment:

❖ Permission is hereby given for any medical/surgical procedure, X-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Psychiatrist, Physician Assistant, or Nurse Practitioner.

❖ I understand I have the right to see a Psychiatrist if I so choose and have the right to see a Psychiatrist prior to any prescription drug or device order being carried out by an Advanced Practitioner.

❖ In the case of an un-emancipated minor, the consent below is being given on his or her behalf

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____

☐ I do not authorize information to be released to anyone but myself

Tell us which number we can leave a message/voicemail

1. _____ __ Can leave a message
2. _____ __ Can leave a message
3. _____ __ Can leave a message

Acknowledgement of Privacy Rights: By signing below, I acknowledge that I am aware of the Integrated Psychiatric Services (IPS) Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at IPS. We may disclose your medical information to people outside of the system, such as Health Information Exchanges. IPS Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy. I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: _____ Date: ____/____/_____

Print Name: _____

Email: _____