CROWNVIEW MEDICAL GROUP, INCORPORATED

CONSENT FOR TREATMENT

I hereby authorize and request **CROWNVIEW MEDICAL GROUP, INC** to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, CROWNVIEW MEDICAL GROUP, INC can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychotherapeutic process can initiate and bring up uncomfortable feelings of and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient/Guardian Signature _____ Date _____

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT'/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize **CROWNVIEW MEDICAL GROUP, INC** to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative_____

Relationship to Patient _____

Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Protection Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosures