Salisbury Psychiatric Associates, PC

Authorization/Consent for Treatment

Authorization for Treatment:
I voluntarily request and consent to initial and routine medication management and therapeutic services by physicians, nurse practitioners, therapists, and healthcare providers at Salisbury Psychiatric Associates. I authorize the performance of appropriate medication management treatment, diagnostic, and therapeutic treatment that may be determined necessary or beneficial by the physician, nurse practitioner, or therapists in the care of the patient. I understand that the practice of behavioral medicine is not exact science and acknowledge that no guarantees have been made as to the results of treatment or care. I further understand that this consent shall remain in effect until I notify Salisbury Psychiatric Associates verbally or in writing of my desire to withdraw my consent for treatment.

Authorization for Emergency Treatment:
In case of an emergency, I authorize Salisbury Psychiatric Associates to obtain emergency treatment from patient's family physician or local hospital emergency room and/or the use of an ambulance. I understand that the minimum necessary health information, written or verbal, may be released to emergency treating providers to meet the needs of the emergency.

Signature of Patient	Date
Signature of Legally Responsible Person	Relationship to Person
Print Name of Legally Responsible Person	Signature of Witness (required only If signature is an "X", mark or symbol
Date	

January 2008

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