PEDIATRIC ASSOCIATES OF DURANGO

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Streusand Consent

Patient Name: _____ DOB: _____

Consent for Evaluation / Treatment

We / I do hereby consent to psychiatric evaluation / treatment by William C. Streusand, MD.

I grant Willian C. Streusand, MD the permission to use and disclose my Protect Health Information (PHI) to the following people:

_____

If not signed by patient, please indicate relationship to patient (e.g., parent, spouse)

_____

Patient, Parent or Guardian Full Name	Patient, Parent or Guardian Signature	Date

(when required)

Client Signature	Date

Witness Signature	Date