CITYVIEW PSYCHIATRY, P.A.
DEBRA ATKISSON, M.D., P.A.
6320 SOUTHWEST BLVD., SUITE 207
FORT WORTH, TEXAS 76109
(817)735-4430 FAX (817) 735-4565

CONSENT FOR TREATMENT

Patient Name:_____________________________________ Date of Birth:___________________
I, ___________________________ hereby give my consent for Debra Atkisson, M.D. to give treatment which may include prescribing medication and or therapy for the above patient.

____ _____________________________
SIGNATURE OF PATIENT / GUARDIAN DATE SIGNED

____ ____________________________
WITNESS DATE SIGNED

RELEASE OF INFORMATION

Patient Name: ________________________ Date of Birth: _____________________
I, __________________________hereby give permission for Dr. Debra Atkisson to Send, Receive and /or Give verbal and/or written information to or from: ________________________________, _ Primary Care Physician and ____________________________________ pertaining to any medical, psychological, alcohol/ drug abuse, social, vocational, and/or educational information concerning the above patient. This consent may be revoked at any time by the patient/guardian named above without revocation. I also understand that this consent will remain in effect as long as the above patient remains in treatment.

____ __________________________
Signature of Client/Guardian Date Signed

____ __________________________
Witness Date Signed

Please list Name Address & Telephone numbers of the above: ___________________________________
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