The Haymount Institute for Psychological Services

Authorization for Participation in Treatment

I, _____, hereby give authorization for
Patient Name
_____ to be involved in all
Individual Named

aspects of patient care at the Haymount Institute for Psychological Services, including but not necessarily limited to participation in therapy, exchange of information, and treatment planning. I understand this authorization will be in full effect until I deem that I no longer wish for the individual named to be involved in the care of my treatment, at which point I will provide a written statement retracting this authorization.

_____ _____
Patient Signature Date

_____
Printed Name of Patient

_____ _____
Witness Date

PTID: RECEIPTENTID: RECORD#: