

**UNIVERSITY OF MIAMI BEHAVIORAL HEALTH (UMBH)**

**Informed Consent**

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I, \_\_\_\_\_ consent to receive psychotherapy/medication management services from a provider affiliated with University of Miami Behavioral Health (UMBH). Psychotherapy is a cooperative effort and I understand that a cooperative effort is needed to resolve difficulties. My choice has been voluntary and I may terminate therapy at any time.

I, \_\_\_\_\_ the legal parent/guardian of \_\_\_\_\_ consent to his/her treatment from a provider affiliated with University of Miami Behavioral Health (UMBH). Psychotherapy is a cooperative effort and I understand that a cooperative effort is needed to resolve difficulties. I understand that the content of my child's therapy may not be discussed with me, but that I am welcome to attend family sessions as appropriate.

**Authorization for Release of Medical Information**

Open communication between your primary care physician and / or the therapist that referred you to this office is important. If medications are needed, it is best that your primary physician and/or therapist know what medications you are taking. In addition, these members of your health care team will have a better understanding of your needs.

I give consent for all psychotherapy team members at UMBH to have access to my treatment record and medications for continuity of care.

Please check one: **Yes** **No**

I authorize \_\_\_\_\_ (Therapist) to give my Primary Care Physician/Referring therapist the following information.

Please check one: **Medication only** **Medications and treatment plan**

\_\_\_\_\_  
Signature of patient/parent/guardian Date

\_\_\_\_\_  
Witness

I do not want my primary care physician or therapist as named above to have information concerning my medications or treatment.

\_\_\_\_\_  
Signature of patient/parent/guardian Date

\_\_\_\_\_  
Witness

**Authorization for Release of Information for Utilization Management and Payment**

I authorize the release of medical information resulting from this referral and ancillary services to University of Miami Behavioral Health (UMBH).

\_\_\_\_\_  
Signature of patient/parent/guardian Date

\_\_\_\_\_  
Witness