Joseph Holmgren, MD

26 Court Street
Suite 502
Brooklyn, NY 11242

917-342-2680
josephholmgrenmd.com
josephholmgrenmd@hushmail.com

Treatment Consent

I, _____, consent to psychiatric evaluation and treatment by Joseph Holmgren, M. D. I understand that he does not, and cannot, guarantee any specific results. I understand that his ability to help me depends on the completeness and accuracy of the information provided to him.

I acknowledge review of the Notice of Privacy Practices located online at
http://josephholmgrenmd.com/s/PrivacyPracticesNotice.pdf
and I have had an opportunity to ask questions about the Notice of Privacy Practices. If requested, Dr. Holmgren has given me a paper copy of the Notice of Privacy Practices. Dr Holmgren reserves the right to revise the Notice of Privacy Practices at any time.

I hereby give my consent to Joseph Holmgren, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I consent to the exchange of information, such as diagnoses, medications prescribed, medical records, and diagnostic test results, between Dr. Holmgren, hospitals, and other treating professionals when necessary to facilitate treatment. Otherwise, I understand that psychiatric records are confidential and privileged and will not be released to anyone without proper written authorization, unless legally required.

With this consent, Dr. Holmgren may:
-Call my home or other location
-Text me
-Email me
-Send me information through the mail
in reference to any items that assist in TPO, including but not limited to appointment reminders, bills, lab results, prescriptions and evaluation forms.

I may revoke my consent in writing except to the extent that Dr. Holmgren has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, I understand that Dr. Holmgren may decline to provide treatment to me.

I have reviewed and I agree with practice policies and payment agreements located at
http://josephholmgrenmd.com/s/PracticePolicies.pdf
If requested, Dr. Holmgren has provided me with a paper copy of his Practice Policies.

Dr. Holmgren has provided me with his personal cell phone number, which I will use only in the case of a serious emergency such as feeling suicidal, violent, or I am experiencing a serious medication side effect. In the unlikely event that I cannot reach Dr. Holmgren, I will call 1800-LIFENET or go to the nearest emergency room.

Printed Name:_____

Signature:_____ **Date:**_____