

Eclipse Mental Health Services
Dr. Dustin O. Hayes D.O.
General Practitioner specializing in psychiatric treatment

Eclipse Mental Health Services
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CONSENT FOR TREATMENT

I am an independently practicing professional. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are electronically maintained, in accordance with HIPAA and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Dustin O. Hayes D.O.. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

Signature of Patient

Date Signed

Signature of Parent, Legal Guardian or Conservator

Date Signed

Signature of Witness (if appropriate)

Date Signed