Psychiatry Authorization for Treatment
This is a Legal Document

Authorization for Treatment:
If you need any medical, dental, family planning, or hospital services in New York State you must give your permission. This authorization form will allow us to provide the services for you. In the case of an emergency, authorization is not necessary.

I hearby authorize Dr. Stephanie Achilles to provide care to myself.

_____ _____
Print Patient Name Date

_____

Patient signature

Please initial next to each item below:

_____ I understand that this office has 7 business days to respond to a request for a refill of medication and will give sufficient notice when I am due for a refill of my medication.

_____ This office is contracted to provide psychiatric assessment and medication management during active college semesters only. There is not coverage during holiday and summer breaks and I am responsible for coordinating with my home providers while school is not in session.

_____ I consent to the use of telehealth/virtual visits. I will be in a quiet, private location with a strong internet connection to be able to conduct these appointments.