Mary C. Nowlin, DO, DLFAPA, DFAACAP, FACN

Child Adolescent and Adult Psychiatrist

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CONSENT FOR TREATMENT

As you know, I share an office with Counselors at the Glendale office and at the Doan Counseling in Scottsdale AZ. I am an independently practicing professional and share only office space with these two Counseling Centers. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained 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 Mary C. Nowlin, DO. 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