JEFFREY SIMON MD
ADDICTION MEDICINE & PSYCHIATRY
1930 Marlton Pike East, Suites U 99 & U 100 • Cherry Hill, NJ 08034
Phone: 856-888-1326 Fax: 856-281-9898

PATIENT'S CONSENT TO TREATMENT

I, _____, hereby give permission to Dr. Jeffrey Simon, M.D., to conduct such treatment services as are deemed necessary to diagnose, measure and alleviate the psychological, social, and/or physical conditions associated with my mental health problems. I realize that written and computerized records will be kept about me and that evaluative data will be requested from me periodically, to ascertain my progress. Such data will be kept confidential, and no information which might identify me will be released without my written consent, except in the case of a medical emergency.

Furthermore, I understand that I have the right to refuse any recommended treatments, and to discuss any forms of potential treatment and possible ill effects with Dr. Simon.

In the event any medication or procedure is prescribed, I understand that I am entitled to a full explanation of the potential risks associated with such medication or participation that Dr. Simon is obligated to discuss with me, and gain my approval, on all established plans before such plans may be instituted.

DATE: _____

SIGNATURE: _____

WITNESS: _____