BUEN CAMINO
PSYCHIATRIC & MENTAL HEALTH CLINIC

Consent for Psychiatric Evaluation and Treatment

I voluntarily give my authorization and consent to receive outpatient diagnostic and treatment services from Claudia Cruz, DNP, PMHNP-BC, at Buen Camino Psychiatric & Mental Health Clinic, LLC. I understand that the following information will be provided to me:

- Benefits of the proposed treatment
- Alternative treatments
- Manner in which the treatments will be provided
- Expected side effects from treatment and/or risks of side effects from medication
- Probable consequences of not receiving treatment

I have the right to withdraw my consent from evaluation and treatment at any time by providing a written consent or verbally notifying Dr. Cruz.

I have read and understood the above. I have had the opportunity to ask questions about this information, and I consent to the evaluation and treatment, if needed. I understand that I have the right to ask questions about the evaluation or treatment at any time.

Patient or Guardian Printed Name and Signature Date