

# Consent Form for Psychiatric Evaluation

Date: \_\_\_\_\_

To Whom It May Concern,

I, **[Patient's Name]**, hereby give my consent for a psychiatric evaluation appointment with **[Psychiatrist's Name]** at **[Clinic/Hospital Name]**.

I understand that this evaluation is intended to assess my mental health status and will involve discussions about my personal history, behaviors, and any symptoms I may be experiencing.

I acknowledge that I have been informed about the purpose of the evaluation and that I have the right to ask questions regarding the process.

I also understand that this evaluation is confidential, and my information will be protected in accordance with HIPAA regulations.

By signing below, I agree to proceed with the psychiatric evaluation and understand my rights concerning my health information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you.

Sincerely,  
**[Your Name]**  
**[Your Contact Information]**