

The Fort Christian Psychiatric Center/ Shaw Wendi Fortuchang, M.D., P.C.

Shaw Wendi Fortuchang, MD, FAPA

110 North Park Drive, Fayetteville, Georgia 30214

770-376-6726 (office) 770-376-6727 (fax)



## General Consent Form

I, \_\_\_\_\_, consent to allow representatives of The Fort Christian Psychiatric Center / Shaw Wendi Fortuchang, M.D., P.C., to speak with the following individual(s) regarding my child's psychiatric treatment:

**Contact #1:**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Number \_\_\_\_\_

**Contact #2:**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Number \_\_\_\_\_

**Contact #3:**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Number \_\_\_\_\_

**Contact #4:**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Number \_\_\_\_\_

Consent will remain in effect, indefinitely, unless otherwise indicated by you in writing.

Parent's/Legal Guardian's Printed Name: \_\_\_\_\_

Parent's/Legal Guardian's Signature: \_\_\_\_\_

Today's Date: **Month:** \_\_\_\_\_

**Day:** \_\_\_\_\_

**Year:** \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_