

The Promedica Research Center  
4460 Atlanta Highway  
Suite B  
Loganville, GA 30052

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AUTHORIZATION FOR TREATMENT AND UTILIZATION REVIEW

I understand that treatment at The Promedica Psychiatry Group may include the following services: psychiatric evaluation, medication management, medication administration, laboratory testing, side effect assessment, nursing assessment, basic laboratory procedures, medical history, health assessment, crisis intervention, psychoeducation, reintegration training, group psychotherapy, family therapy, individual therapy, psychometric evaluations and assessment, and referral to outside healthcare providers.

I understand that I may receive one or more of the services listed above according to my needs. I consent to such treatment as delivered by the staff at The Promedica Psychiatry Group. I also authorize for my case to be reviewed from time to time to assure that these services are appropriate to my needs. In such cases where I may have insurance coverage for the services, I authorize the staff at The Promedica Psychiatry Group to converse with insurance case managers as needed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date