GENERAL CONSENT FOR CHILD OR DEPENDANT TREATMENT

Patient Name: _____ DOB: _____

- I/We am the legal guardian/legal representative of the patient and on the patients behalf, I/we legally authorize the practitioner/group to deliver mental healthcare services/prescribe medication to the patient.

_____ _____

Print Name Signature of Legal Guardian/Legal Representative

_____

Date

_____ _____

Print Name Signature of Legal Guardian/Legal Representative

_____

Date