Consent for Psychiatric Treatment and Minor's Medical Information

Name: _____ for_____

☐ Mother ☐ Father ☐ Legal Guardian ☐ Minor's Name

DOB_____ hereby voluntarily consent to the rendering of psychiatric care with medication by Joyce Weckl, PMHNP, as may, in her professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to _____

(Name of Person)

Who will be caring for our (my) child _____

(Name of Minor)

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature: _____ Date: _____

(Mother, Father or Legal Guardian)

Print Name: _____ Date: _____

(Mother, Father or Legal Guardian)