DALLAS FAMILY PSYCHIATRY

CONSENT OF GUARDIAN TO MENTAL HEALTH TREATMENT

As the legal custodian/guardian of _____ , a minor whose birth date is _____, I am authorized to act on behalf of the individual/minor in making healthcare decisions, and I hereby consent to medical health treatment (excluding inpatient psychiatric hospitalizations and psychotropic medications) for the individual.

____ Psychiatric Evaluation

____ Medication Management

It is understood that such treatment will take place at

Dallas Family Psychiatry LLC
3701 W Northwest Hwy, Building 1, Suite 189 Dallas, TX 75220

THE ABOVE CONSENT IS VALID UNTIL_____

AND IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS: _____

_____

The costs, nature and purpose of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment have been explained to me. I understand that my refusal to consent to any of the above services may result in these consequences:

_____

_____

I retain the right to revoke this authorization with written notice to the above-named provider prior to the expiration date. This authorization is valid until the minor/individual is released from the specific treatment and/or until _____/_____/_____.

Date _____

_____
Guardian/ Legal Representative

Witness _____

By _____ date:_____
Authorized Agent

_____
Address/Telephone