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

Mental Fitness Psychiatry LLC
10300 North Central Expressway, Suite 325, Dallas, TX 75231

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