

PSYCH ASSOCIATES OF MD, L.L.C.

CONSENT FOR TREATMENT OF A MINOR

As custodial parent, I authorize Psych Associates of MD, L.L.C. to provide evaluation and treatment of my minor child, _____.
(print name)

I also give permission for my child's treatment team to consult with clinicians and other primary care physicians associated with the care of my child. I understand that such consultation helps ensure quality care for my child.

Signature of parent or guardian

Signature of witness

Date: ____/____/____

If the parents of this child are not living together, we will need a copy of the court document that explains custody arrangements. If there is joint medical custody, we will need both parents to sign the consent form **before the child can be seen**.

Second parent (if joint medical custody), please complete below:

Signature of parent or guardian

Signature of witness

Date: ____/____/____

OR if there is no court order, it is illegal for us to withhold medical information from the other parent. Please sign below to indicate you have read and understand this:

Signature of parent or guardian

Signature of witness

Date: ____/____/____