Austin
Mind and
Behavioral
Health

AUSTIN MIND AND BEHAVIORAL HEALTH

CONSENT FOR TREATMENT FORM FOR MINOR

I, the undersigned, for a minor (under the legal age of 18), for whom I am the legal guardian, hereby consent for psychiatric evaluation, psychiatric care and treatment as ordered/recommended by the provider at Austin Mind and Behavioral Health. This consent is provided for provision of outpatient services, office visits and ongoing outpatient care. I consent to provision of services by a midlevel provider (Nurse Practitioner or Physician Assistant), under the direction of the psychiatrist. I acknowledge that no guarantees have been made to me by the providers in this clinic, as to the results and of improvement in my condition.

I acknowledge that I have the right to discuss the assessment, potential risks, and benefits of any recommended treatment.

Name of Minor: _____ Date of birth _____
Relation to person providing consent: _____

I certify that I have read and fully understand the above consent statements and that I am providing this consent voluntarily, without any coercion.

Signature of Legal Guardian Date

_____ _____