Consent to Treat a Minor

Patient (Minor's) Name: _____ DOB: _____

Mother's Name: _____

Address: _____

Father's Name: _____

Address: _____

(Please circle all that apply)

Marital Status: Married (to other parent) Separated Divorced Single Widowed

Legal Custody: Both Parents (Shared) Mother Father Court Guardian

Other: _____

Authorization for treatment with the following physician, therapist and related clinicians.

_____
Clinician Name

_____
Clinician Name

_____
Clinician Name

_____
Clinician Name

Note: *If custody is other than both parents (married/intact relationship), or single parent family, decree of divorce indicating custody and visitation must be attached. If parent is on probation or under court order, court documentation must be attached.*

I/We affirm that as of (date) _____/_____/_____, have custody of the above named minor and that I/we do hereby consent for medical/psychiatric treatment of above said child/minor to an ED-180 program, Dr. Jeffrey Desarbo and/or clinician associated with ED-180. I hereby further claim that I/we, without intent to defraud or misrepresent, have the sole authority to legally request consent for treatment for the above named minor to an ED-180 program, Dr. Jeffrey DeSarbo and/or clinician. I/we attest that this form has been completed and signed in full good faith with accuracy and no deception.

_____ _____ _____
Signature of Parent 1, Guardian, Officer of Court. Print Name Date

_____ _____ _____
Signature of Parent 2, Guardian, Officer of Court. Print Name Date