



CONSENT FOR COUNSELING AND/OR PRESCRIBING MEDICATIONS FOR MINOR PATIENTS

I, \_\_\_\_\_, (Printed name of parent or legal guardian) acknowledge I have previously given general consent to Sutton Place Behavioral Health, Inc., for counseling and/or prescription of medications for \_\_\_\_\_ (Printed name of patient).

I understand that having given this initial consent, there may be times or situations when I cannot be physically present at a given appointment to approve treatment and/or medication changes for \_\_\_\_\_ (Printed name of patient).

Under such circumstances, by my signature, I hereby authorize \_\_\_\_\_ to consent to counseling/medical treatment for the above named child. The person so authorized to give this consent is related to the child as follows: (Check one)

{ } An adult who has care and control of the child.

Dated this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Parent of Legal Guardian

\_\_\_\_\_  
CLIENT NAME

\_\_\_\_\_  
CID