Gene Fletcher, D.O. , P.A.

Child, Adolescent and Adult Psychiatry

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CONSENT FOR TREATMENT

PATIENT NAME: ______________________________________ ___________
Last First Middle Date of Birth

For Patients Under 18 years of age:

I certify that I am the Father Mother Legal Guardian of the
(Circle One)
above named child and I hereby give my authorization and consent for the above named child to receive Psychiatric Outpatient Diagnostic and Treatment Services. This includes use of "Off Label" Medications.

Father: ____________________________Date: ____________

Mother: ____________________________ Date: ____________
OR
Legal Guardian: _____________________ Date: ____________

For Patients Over 18 years of age:

I certify that I am the patient named above and I hereby give my authorization and consent to receive Psychiatric Outpatient Diagnostic and Treatment Services. This includes use of "Off Label" medications.