

# Parent Consent for Treatment of Minors

Nicodemus M. Watts, MD

This is to authorize Nicodemus M. Watts, M.D., to evaluate and/or treat my child,

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(Child's full name)

I understand that the evaluation and/or treatment process may include counseling and/or medication, may involve other members of the family and the exchange of information with other professional agencies and individuals with a signed release of information form. I understand that I have a right to receive a copy of this authorization.

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Signature of Parent / Legal Guardian	Printed Name	Date
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Signature of Patient	Printed Name	Date
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Witness Signature	Printed Name	Date
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