

Consent For Outpatient Treatment

This document is to obtain your informed consent for evaluation and treatment. Please ask for clarification if you don't fully understand the recommendations.

I hereby consent to a psychiatric evaluation and subsequent treatment, subject to my ongoing involvement in providing consent. I understand that if I wish to accept treatment I have the right to have the risks and benefits of treatment options, including not having any treatment, explained to me to my satisfaction. I understand that I may at any time refuse any intervention in which I do not wish to participate.

Signature of Patient

Date: _____ Time: _____

OR

Printed Name of Representative

Signature of Representative

Description of Representative's Authority
(e.g., Legal Guardian or Durable Power of Attorney)

Address Line 1

Prairie View Representative

Date: _____ Time: _____

Address Line 2

Phone: _____

Date: _____ Time: _____