# 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,

_____

(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.

_____

Signature of Parent / Legal Guardian  Printed Name  Date

_____

Signature of Patient  Printed Name  Date

_____

Witness Signature  Printed Name  Date

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