Medical Treatment Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

To Whom It May Concern,

I, the undersigned, hereby consent to receive mental health treatment under the care of [Provider's Name], at [Facility Name]. I understand that the treatment may include, but is not limited to:

- Psychotherapy
- Medication Management
- Psychological Assessments

I have been informed about the nature of the treatment, the potential risks and benefits, and my right to withdraw consent at any time.

By signing this form, I acknowledge that I have read and understood this consent form, and I agree to participate in my treatment plan.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if applicable): _____

Date: _____