German Corso, M.D. , P.A.

Child and Adolescent Psychiatry
ADHD and behavioral disorders Clinic

CONSENT FOR TREATMENT

PATIENT NAME: _____ _____
Last First Middle Date of Birth

I certify that I am the Father Mother Legal Guardian of the above
(Circle One)
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 if necessary.

Father: _____Date: _____

Mother: _____ Date: _____

OR

Legal Guardian: _____ Date: _____