

Patient Consent Form

I _____ am providing consent
Patient's name (Please Print)

to receive treatment for _____
Disorder being treated

with the following treatment/medications(s):

I understand the following:

- That I have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including _____

- That I have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

_____ Date _____
Patient signature

_____ Date _____
Treatment provider