Columbus Psychiatry

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CONSENT FORM

Permission is hereby granted to the clinicians of Columbus Psychiatry to provide outpatient mental health services as necessary to diagnose, treat, and care for

the needs of _____,who is a minor, and under
(child's name)
the care of his/her parent or legal guardian.

I understand that the psychiatrist and I, the parent/guardian, will clarify how and/or what information will be conveyed about my child. I understand that under some circumstances confidentiality may be crucial for my child to establish a therapeutic relationship.

I have read this consent form and I certify that I understand its contents.

Signed:

_____ Date:_____
Parent/Guardian