CONNECTICUT CENTER
FOR PSYCHIATRIC WELLNESS

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Consent for Care and Treatment of Minor Patient

Patient Name (First, Middle, Last):		Date of Birth:	Today's Date:
Sex at Birth: ❑Male ❑Female	Social Security Number:	Affirming Parent or Guardian's Name:	

I, the undersigned, having reached the age of majority in The State of Connecticut, do hereby certify that as of this date, I have the legal right to select and authorize healthcare services for the minor patient named above.

I hereby request and authorize CCPW to perform diagnostic testing and render appropriate medical care and or treatment to the minor patient named above.

This authorization also extends to all practitioners and office staff members and is intended to include radiographic examination, modalities, therapies, diagnostic procedures, and the like, at the practitioners' discretion, and upon his/her order.

{If applicable}
Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse of other parent is not required. If my authorization to select and authorize this care is to be revoked or modified in any way, I will immediately notify this office.

Signature of Guardian

Date

Printed Name of Guardian

Relationship to Minor

Signature of Witness

Printed Name of Witness

If Guardian's Signature is Not Witnessed in Person:
Subscribed and Sworn Before Me this _____ day of _____ 20_____, as personally known to me or having provided acceptable government-issued photo identification, I hereby set my hand to this instrument as duly sworn and authorized:

Signature of Notary Public / Comm. Superior Court

Name Printed

Date

My Commission Expires