Valley Psychiatric Associates

Child, Adolescent, and Family Psychiatry

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Date: _____

I, _____, the _____ of _____, am authorizing
Please print your full name *relation to patient* *full name of patient*

_____ to be able to consent for medical treatment for _____ on my behalf.
Full name of non-parent bringing child *full name of patient*

_____
Signature of Parent, or Guardian

_____
Witness