

TRIAD PSYCHIATRIC AND COUNCELING CENTER, PA

Authorization to Consent to Health Care for Minor

I, _____, am the parent and/or legal guardian of _____, date of birth _____. I hereby authorize _____ in whose care the minor is currently abiding, and who resides at _____, to consent to any service which may be necessary or proper for the health care of the above said minor. This includes, but is not limited to, the power to provide any health care at any hospital, out-patient facility, or other institution and consent to psychiatric treatment, administration of psychiatric medication, and psychotherapy.

By signing below, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and the full import of granting this power to the agent named herein.

Parent/Legal Guardian

Date

STATE OF NORTH CAROLINA

COUNTY OF _____

On this _____ day of _____, _____, the person described in and who executed the foregoing instrument, _____, personally appeared before me, to me known and known to me, and he/she acknowledges that he/she executed the same and being duly sworn by me, made oath that the statements in the foregoing instruments are true.

Notary Public _____

My Commission Expires: _____

(OFFICIAL SEAL) (1993, c. 150, s. 1; 1999-456, s.59.)