PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

CONSENT FOR EVALUATION, PSYCHOTHERAPY, PSYCHOPHARMACOLOGY AND/OR TREATMENT OF A CHILD

A child aged 17 years and under must have the consent of his/her (custodial) parent or guardian to receive psychiatric services including psychotherapy, evaluation, or other treatment. *In cases of divorce, only the custodial parent can give consent.*

So that we can comply with the law, please complete the following:

Check and initial one:

_____ I am the parent of the below named minor child. There have been no divorce or legal separation proceedings between the child's other parent and myself.

_____ I am the custodial parent of the below named minor child as designated in divorce proceedings. I understand that I must furnish a notarized copy of the divorce decree section stating that. I agree to provide this office with a notarized copy of any changes in custodial status of the child.

_____ I am the (custodial) parent of the below named minor child. My spouse and I have a legal separation.

_____ I have joint custody with my ex-spouse of my child.

_____ I am the below named child's legal guardian. I understand that I must furnish a notarized copy of the guardianship papers.

_____ I am the sole legal parent of the below named minor child.

I agree to inform the office if there are any changes in my child's custodial status for any reason. I hereby give my permission for Psychiatric Associates of Arkansas, PLLC, (to include Duong Nguyen, M.D.; Richard Owings, M.D., Ph.D.; Philip Mizell, M.D.; Marcela Johnston, Ph.D.; Nancy (Beach) Golden, LPEI; Garry Teeter, LPC; Nancy Kozlowski, LPC; Lindsay (Crane) Oliver, LPC; Ally Orsi, LCSW) to provide psychiatric services for:

____ DOB: ______________________

(Name of Minor Child)

Under penalty of perjury, I swear that all information provided by me on this form is true to the best of my knowledge.

As the custodial parent, I authorize release of information on my child to the following: (please enter names of everyone who may receive information, such as non-custodial parent, step-parent, grandparents, attorney, physician, etc.)

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____ Date: ______________________

(Parent, Legal Guardian or Custodial Parent)