

Neal Mazer, MD, MPH  
110 ½ E. De La Guerra Street  
Santa Barbara, CA 93101

## Consent To Treat Minor

I, \_\_\_\_\_  
(the parent(s) / legal guardian - *please print*)

give permission to: Neal Mazer, MD, MPH (psychiatrist)

to treat my child, \_\_\_\_\_ (name of child) rendering  
psychotherapy and prescribing of medications, **except** as indicated below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Without exception: \_\_\_\_\_

With the following exception: \_\_\_\_\_

The types, intended effects, and potential side effects of the, psychotropics medications, neuroleptic medications, sleep medication, anti-psychotic medications, stimulant medications, anti-depressant medication, anti-anxiety medications, and other medications, which may be employed in dosages and frequency to be determined by Dr. Neal Mazer, have been discussed to my satisfaction.

I recognized further questions can be requested of Dr. Neal Mazer at any time, and or sought from the pharmaceutical package insert.

It is without pressure or coercion that I sign this consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent / legal guardian)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent / legal guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
Neal Mazer, MD, MPH

This is until termination of treatment or notification to Neal Mazer, MD, MPH in writing, unless stipulated below:

Effective date: \_\_\_\_\_ End date: \_\_\_\_\_