

Neal Mazer, MD, MPH
110 1/2 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 provide psychotherapy and medication management for my
child(ren) listed below:

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 effective for one year after date of signing unless stipulated
below:

Effective date: _____ End date: _____