FAITH BEHAVIORAL HEALTH, PLLC

Sadaf Noor, M. D.

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PARENTAL CONSENT FORM FOR PSYCHIATRIC TREATMENT OF A MINOR CHILD

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Name of the Child (Please Print)

_____ _____

Name of Father Name of Mother

_____ _____

Signature of Father Signature of Mother

_____

If Parents Are Divorced: Name of Custodial Parent or Legal Custodial Guardian – Attach Copy of Final Divorce Decree With Court Clerk's/Judge's Signature and Seal

STATEMENT OF THE NATURE OF THE MEDICAL, PSYCHOLOGICAL OR PSYCHIATRIC TREATEMENT TO BE GIVEN

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Date Treatment to Begin:

DECLARATION THAT I/WE AM/ARE LEGALLY AUTHORIZED TO HAVE THE MINOR CHILD LISTED ABOVE EVALUATED AND OR TREATED BY DR. SADAF NOOR. IF DIVORCED I WILL PROVIDE, PRIOR TO ANY EVALUATION OR TREATMENT, A COPY OF MY/OUR FINAL DIVORCE DECREE SIGNED BY ALL PARTIES INCLUDING THE COURT CLERK, JUDGE SHOWING PROOF THE DECREE HAS BEEN ENTERED INTO AND FILED WITH THE COUNTY COURT OF RECORDS. THIS DECREE NAMES ME AT THE CUSTODIAL PARENT GIVING ME FULL PRENTAL RIGHTS OF MEDICAL TREATMENT FOR THIS CHILD.

_____ _____

Custodial Parent/ Legal Guardian Printed Name Custodial Parent/Legal Guardian Signature and Date