Meadowlark Psychiatric Services
320 W. Cherry Street
North Liberty, IA 52317
319-626-3300

CONSENT TO TREAT A MINOR

☐ If not applicable please check box and continue to next page

DATE: ______________________

PARENT/LEGAL GUARDIAN INFO

NAME: ____

ADDRESS: ____

CITY: __________________________________ STATE: ______ ZIP: ________

PHONE: _______________________________ SS#: _____________________

I HEREBY AUTHORIZE:

The above named doctors or any doctors associated with the above named practice, and whomever he/she/they may designate as assistants, to administer the required care as deemed necessary to my (indicate relationship of child) _______________________

(Name of Child) ____

SIGNED: ____

WITNESSED: ____