Minor Consent & Confidentiality Fact Sheet

Under Arizona law, minors under 18 years of age may not alone consent to mental health treatment.[1]

Mindpath Health requires the following with respect to treatment of minor patients in Arizona:

- For minor patients under age 18:
  - The minor patient's parent(s) or legal guardian must sign the Consent to Treatment and Consent to Medications forms on the minor patient's behalf

[1] Arizona Revised Statutes § 36-2272.

MINDPATH HEALTH

Consent to Treatment

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Mindpath Health for the purpose of diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Mindpath Health's providers include psychiatrists, psychiatric mental health nurse practitioners, physician assistants, psychologists, counselors, social workers, and marriage and family therapists. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor under the age of 18 and I am consenting to treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my **Consent to Treatment** at any time.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

If you are signing this **Consent to Treatment** as a parent, legal guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Legal guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name