T. Atilla Ceranoglu, M.D.

Child and Adolescent Psychiatry

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by T. Atilla Ceranoglu, M.D. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

____ ________________

Signature of Patient Date Signed

____ ________________

Signature of Parent, Legal Guardian or Conservator Date Signed

____ ________________

Signature of Witness (if appropriate) Date Signed

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