Cheryl A. Dasler, M.D.
BOARD CERTIFIED IN GENERAL PSYCHIATRY AND CHILD AND ADOLESCENT PSYCHIATRY

PARENTAL AGREEMENT AND TREATMENT AUTHORIZATION

Patient: _____ DOB: _____

Mother's name (printed): _____

Father's name (printed): _____

A. For parents who are divorced or separated, and share medical decision making, the following must happen before their child can be seen:
    1. When one parent is unable to attend a psychiatric appointment for their child, the parent in attendance will be responsible for relaying information and decisions made to the other parent. Dr. Dasler will not be the go-between for communication between the parents.
    2. Both parents must sign this statement of authorization, indicating their consent for Dr. Dasler to treat their child in their absence, when only one parent is able to attend a scheduled appointment.

B. If parents are divorced, and one parent has sole medical-decision making rights, Dr. Dasler will require court documentation detailing this designation. If this is the case, this form does NOT to be signed by either parent.

We, the above named individuals, share medical decision making for our child _____.

By signing below we indicate our agreement and understanding of the above stipulations regarding parents with joint medical decision making who are divorced or separated.

Mother's signature: _____ Date: _____

Father's signature: _____ Date: _____