Placer County Systems of Care

CONSENT FOR MENTAL HEALTH EVALUATION AND/OR TREATMENT OF A

I, _____, hereby consent to mental health evaluation and treatment for _____, a minor child, by Placer County Systems of Care.

_____	_____
Signature	Relationship to Patient
_____	_____
Authorization	Date
_____	_____
Witness	Date

Placer County Systems of Care

AUTORIZACION PARA SALUD MENTAL EVALUACION Y TRATAMIENTO DE UN

Yo, _____, con mi firma, doy mi permiso para evaluacion y tratamiento de salud mental para _____ un menor, de Placer County Systems of Care.

_____	_____
Firma	Parentesco con el Paciente
_____	_____
Autorizacion	Fecha
_____	_____
Testigo	Fecha

MINOR

_____

_____

_____

MENOR

_,

_____

_____

_____