**Consent to Treatment**

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Teshera Tull-Yearwood, PMHNP-BC. These services may include medication management, psychotherapy, 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.

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Signature of Patient Date Signed

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Signature of Parent, Legal Guardian or Conservator Date Signed

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Signature of Witness (if appropriate) Date Signed