MINDPATH HEALTH

Consent to Medications

I understand that my provider has recommended prescription of the medication(s) specified below for treatment of my diagnosed illness or condition and I hereby consent to prescription of such medication(s).

Medication
Medication
Medication
Medication

I understand that my provider is required to inform me of the expected benefits, side effects, and risks associated with taking such medication(s), including the following:

1. Nature of my illness or condition and proposed treatment.
2. Reasons for taking the prescribed medication(s), including expected benefits and the likelihood of my condition improving without such medication(s).
3. Reasonable alternative treatments available and their risks and benefits.
4. Name, type, dosage, frequency, method, and duration of the prescribed medication(s).
5. Risks associated with the prescribed medication(s), including potential complications.
6. Common side effects of the prescribed medication(s) and any other side effects likely to occur in my particular case. This includes whether I can continue certain activities and/or take other medications in combination with the prescribed medication(s).
7. Possible additional side effects, such as persistent involuntary movement of the face, mouth, hands or feet, known as tardive dyskinesia, which may occur if I take certain medications (e.g., neuroleptics) and can be irreversible.
8. Any other material information identified by my provider.

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I understand that there may be other risks or side effects associated with the prescribed medication(s) that my provider has not communicated to me and that my condition may not be cured or improved as a result of the prescribed medication(s), and in rare cases, may get worse. I further understand that no particular results can be guaranteed.

I have had an opportunity to ask questions and have had my questions answered to my satisfaction. I understand that I may refuse to sign this consent and may withdraw my consent at any time.

_______________________________	_______________________________
Patient Signature	Date
Patient Name	Patient Date of Birth

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

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

_______________________________ _______________________________
Signature Date

____
Name