COLORADO PSYCHIATRY CENTER

Joint Medical Decision Making Rights

I am the divorced parent of the patient_____.
Print Patient's Name

I give my ex-spouse_____ permission to make medical decisions
Ex-Spouse's Name

on my child's behalf while receiving care at the Colorado Psychiatry Center when I am not present.

_____ _____
Parent Signature Date

I understand that we must manage appointment times and treatment to make joint medical decisions on the behalf of our child _____. I understand that
[Patient's name]
Colorado Psychiatry Center will not serve as mediators of any discrepancies of treatment or appointments. I also understand that if we as the parents of the patient are unable to come to an agreement on the child's care, Colorado Psychiatry Center will discharge my child from the practice until the treatment plan is resolved by both parties. Our practice does NOT provide expert testimony. If CPC is compelled to testify in this capacity for you, you agree to pay CPC $1,000/hour with a two-hour minimum deposit.

This form may not be altered. If this form is signed, the parent or guardian is agreeing to the original form in its entirety.

_____ _____
Guardian Signature Date

_____ _____
Guardian Signature Date
