Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385, 860-572-7711, www.fwcct.com

Empowering LIFE

CONSENT TO EXAMINE AND PROVIDE CARE

Child Full Legal Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Parent(s)/Legal Guardian(s) Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Email: _____
Additional Contact Information: _____
_____

I _____ authorize Family Wellness Centre of Connecticut to examine and provide care if needed to my child (listed above) in an outpatient setting.
I understand that I have the right to withdraw consent at any time in writing. This informed consent remains effective throughout the course of treatment at Family Wellness Centre of Connecticut. I may have a copy of this consent if I so request.

_____
Parent or legal Guardian Signature Date

_____
Signature of client (if over 14 years old or older) Date

_____
Witness Signature Date