



**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.

Guardian Signature Date

Guardian Signature Date

CPC Staff Witness Signature and Date _____