Elizabeth O. Dania

NP in Psychiatry, PLLC

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Psychiatric Mental Health Services
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Consent for Medication

My medication provider has discussed with me the risks, benefits, alternatives, possible side effects, medication interactions, and potential consequences of discontinuing medication treatment.

I understand the information provided to me and have had the opportunity to ask questions regarding my prescribed medication(s).

Medication Name(s): ____

Client Signature: ____________________________________ Date: _________________

Provider Signature: __________________________________ Date: _________________