Regent Mental Health Group, SC
700 Rayovac Dr Ste 103, Madison WI 53711
Ph: 608-238-5826 Fax: 608-238-1221

Medication Acknowledgement Agreement

Patient name:_____ Date of Birth:_____

My signature below indicates:

That I give consent for the medication prescribed to me. I understand the reasons for any prescribed medications. The potential risks and benefits of the prescribed medications have been explained to me by the prescriber. This consent is valid for the duration of my treatment and any subsequent changes in my medication. This consent may be withdrawn in writing by me at any time.

_____ _____
Signature of patient (ages 14 years or older) Date

_____ _____
Signature of legal representative for patient under 18 Date