Stay Designated

Consent to Treat A Minor

This is an authorization to provide therapeutic services for the following individual:

NAME: _____

DOB: _____ **AGE:** _____

SSN: _____

By signing this document, I (Guardian name) _____ hereby authorize _____ (hereinafter "Provider") to provide mental health treatment for the above-named minor.

- I understand that Provider is required to report incidents of child abuse learned about during the course of therapy as explained in the "Informed Consent" form.
- Provider has discussed with me and my minor child the limits of confidentiality.
- Provider has further explained the "holding information policy", what types of information will be shared with me about the above-named minor's treatment, and when we will discuss this.
- I understand Provider may consult with other mental health providers at *Stay Designated* for the purposes of ensuring the best possible care.
- I understand I may withdraw consent for treatment of the above-named minor at any time.

_____ _____

Guardian Signature Date

_____ _____

Gaurdian Signature Date

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