Married Parents/ Joint Custody

PARENT 1

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,_____PARENT NAME_____, authorize mental health treatment services from _____PROVIDER NAME_____ for my son/ daughter, _____CHILD NAME_____, who is _____AGE_____ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to _____PROVIDER NAME_____, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

Parent/ Legal Guardian Printed Name

Parent/ Legal Guardian Signature

NOTARY SIGN/STAMP

Notary Stamp

Date

Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

Married Parents/ Joint Custody

PARENT 2

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,_________PARENT NAME_________, authorize mental health treatment services from _________PROVIDER NAME_________ for my son/ daughter, _____CHILD NAME_____, who is ___AGE___ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to _________PROVIDER NAME_________, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

Parent/ Legal Guardian Printed Name

Parent/ Legal Guardian Signature

NOTARY SIGN/STAMP
Notary Stamp

Date

Date