SINGLE PARENT/ SOLE CUSTODY

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

I,_____*PARENT NAME*_____, authorize mental health treatment services for _____*CHILD NAME*_____, my son/ daughter, who is _____*AGE*_____ years of age. I agree to be present, and when requested, to participate in the treatment process. By signing below I attest that I possess sole decision making rights for all medical care for my child. I hereby hold harmless Union Street Counseling Services LLC., and provider_____*PROVIDER NAME*_____ from any claims made by another parent/legal guardian regarding the above mentioned decision making rights.

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

NOTARY SIGN/STAMP

_____

Parent/ Legal Guardian Signature

_____

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