CONSENT TO TREATMENT OF A MINOR

Please print this form, sign, and bring with you to first counseling appointment. You can also email this form to info@upwardcall.org.

NAME OF MINOR CLIENT :: ____

SOLE LEGAL CUSTODY

By my signature below, I attest that I have sole legal custody of the above named client, and there is no other parent or guardian who has the legal right to information about this client's health or medical treatment.

PRINTED NAME :: ____

SIGNATURE :: ________________________________ DATE :: ____________

SHARED CUSTODY OR JOINT LEGAL CUSTODY PARENTS OR GUARDIAN

By our signatures below, we attest that we have shared custody or joint legal custody of the above named client. We further consent to treatment of the above named client. In the event of shared custody, the undersigned understand that both custodial parents or guardians have the right to access information regarding the treatment process and that either has the power to release records with a properly endorsed release of information.

PRINTED NAME :: ____

SIGNATURE :: ________________________________ DATE :: ____________

PRINTED NAME :: ____

SIGNATURE :: ________________________________ DATE :: ____________