



## Authorization for Outpatient Services to a Minor

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ PATID: \_\_\_\_\_

Legal Guardian #1 Name \_\_\_\_\_ Legal Guardian #2 Name \_\_\_\_\_

I/we hereby authorize Health Solutions West to provide mental health services to the above named minor child. I/we understand that for children under the age of 15, only the parents or other person with medical decision making authority may authorize treatment. I/we have authority to authorize treatment for the above-named minor child because: *[Initial the appropriate basis of your authority to authorize treatment for the child]*

\_\_\_\_\_ I/we am/are the natural or adoptive parent(s) of the child. I attest that there are no court orders that limit my authority to authorize treatment for the child, and no court orders providing any other individual(s) with joint medical decision-making responsibility for this child; or

\_\_\_\_\_ I/we have joint medical decision-making authority for this child pursuant to a court order or decree. *(Documentation of guardianship, court order for treatment, or other medical decision-making responsibility is required, and no psychiatric services will be provided without consultation with all decision making parties); or*

\_\_\_\_\_ I/we have sole medical decision-making responsibility for this child pursuant to a court order or decree. *(Documentation of guardianship, court order for treatment, or other medical decision-making responsibility is required); or*

\_\_\_\_\_ I/we am/are the primary caretaker of this child and the parents or legal guardian are unavailable to provide consent in spite of my/our efforts to contact them. I/we understand that this consent is valid only for outpatient therapy, and that no outpatient psychiatric services will be provided without documentation of court-appointed guardianship. *(Documentation of petition for guardianship or notarized Medical Power of Attorney is required.)*

By signing this authorization, I/we understand that I/we may not request access to the minor child's records in connection with any legal proceeding involving a determination of the best interests of the minor child because the minor child has a right to privileged and confidential communications. I/we understand that Health Solutions West will not produce the minor child's records in that type of legal proceeding without a valid authorization or court order.

If the minor child is fifteen years or older, Health Solutions West, upon a request from a parent or legal guardian, without the consent of the minor child, may advise the parent or legal guardian only of the services given or needed. Release of information regarding services shall not be considered a waiver of the minor child's right to privileged communications or a breach of Health Solutions West's duty of confidentiality.

I/we may request at any time that this authorization be revoked. In any event, the authorization expires when the case is closed. Expiration or revocation of this authorization does not waive any privilege.

I/we declare under penalty of perjury that the foregoing is true and correct.

\_\_\_\_\_  
Legal Guardian #1 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian #2 Signature

\_\_\_\_\_  
Date