CONSENT FOR TREATMENT OF A MINOR

Client Legal Name: _____

Client Preferred Name: _____

Client Date of Birth: _____

I, _____, give my consent to *Inspire Behavioral Health*, to provide treatment and/or therapy necessary or advisable for my child. I understand that I may stop treatment at any time and that *Inspire Behavioral Health* has the same right.

I realize that my child's treatment is confidential. Information may not be released without my written consent except in the event that an issue is raised which, in the clinician's judgement, would endanger my child's welfare. I would be notified, as would appropriate authorities and resources, if indicated (See "Statement Regarding Confidentiality" and "Statement Regarding Release of Information" in our policies document, pages 4-5).

My child's clinician may determine with my child that my participation is needed to treat a specific problem.

_____ _____

Parent/Legal Guardian Signature Date

Address: _____ Phone: _____

_____

_____ _____

Child Signature (if indicated) Date

_____ _____

Witness Signature/Title Date