EastValley
COMMUNITY HEALTH CENTER

Behavioral Health Department
Consent to Treat a Minor

Consent for Treatment of a Minor
Child and Adolescent Data Form

*****PLEASE COMPLETE THIS FORM ONLY IF THE PATIENT IS A MINOR*****

Name of Minor: _____

Age: _____ years old Date of Birth: _____/_____/_____

I, _____, am the legal custodian of above-named minor.
Please print

Please check one of the following options:

☐ I have full legal authority to consent treatment of the minor without obtaining Consent or approval of another person.

☐ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

I, _____, hereby; authorize East Valley Community Health Center staff to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

_____	_____	_____	_____
Print Patient Name	**Signature of Patient or Patient's Representative**	**Relationship to Patient (If not self)**	**Date**

_____	_____	_____
Print Witness Name	**Signature of Witness**	**Date**