RECOVERY PATHWAYS

CONSENT TO TREAT A MINOR

We, ________________________________and ________________________________, are legal custodial
(Parent Name) (Parent Name)
parents with decision-making responsibility for __________________________, a minor. If sole legal custodian,
(Minor's Name)
please attach a copy of Permanent Court Order Provision. We authorize Recovery Pathways, LLC to begin the

mental health assessment and treatment of said minor on _________________.
(Date)
Authorization will be in effect until such time as this psychotherapeutic relationship is terminated. As legal custodial parent, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this Recovery Pathways believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission for Recovery Pathways providers to use their discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my minor child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

IF APPROPRIATE, PARENT WITH DECISION MAKING RESPONSIBILITY FILL OUT AND SIGN THE FOLLOWING:

[ ] I also authorize ____________________________ to sign any and all papers necessary for the client's treatment and participation in treatment.

[ ] I also authorize ____________________________ to transport client to and from scheduled appointments.

____ ________________________
Signature of Parent/Guardian Date

____ ________________________
Signature of Parent/Guardian Date

____ ________________________
Signature of Witness Date

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