Aiding Therapy Services, PLLC

"Because we all need a little help sometimes."

Attestation of Medical Decision Making for Minor Child

Client Name:_____ **Date of Birth:**_____

I, _____ state and attest that I may legally consent to mental health, medical, and/or substance abuse treatment for the above named minor child under the following authority (Please initial):

_____ **Biological/Adoptive parent or Legal Guardian**

_____ **has sole Medical Decision Making Authority** (If you are separated or divorced from the child's other biological parent please provide legal documentation that explicitly states that you have sole medical decision making authority.)

Medical Decision making is shared between:
_____ **and** _____
(In the case of separation or divorce, Aiding Therapy Services, PLLC requires that both parents/legal guardians consent to mental health treatment. As the presenting parent, please provide contact information for the other parent/legal guardian and we will outreach them and ask for their consent to treat the minor:
Address:_____ **Phone Number:**_____

If the other parent/legal guardian is not available to sign, please explain below:

_____ **Self**: Minor over the age of 12 who wishes to consent for services

_____ **Department of Human Services Representative**: (DHS is required to consent to treatment for children in their custody and to provide legal documentation demonstrating they hold medical decision making authority; attach e-signed referral to indicate legal authority and consent for treatment.)

_____ **Other**: please explain below and attach document verifying legal authority:

Please note that without the required legal documents we will not be able to treat the minor child

Parent/Guardian/Client Signature:_____ **Date:**_____

Parent/Guardian/Client Signature:_____ **Date:**_____