The Haymount Institute for Psychological Services

Authorization for Participation in Treatment

I, _____, affirm that I am the legal guardian of
Legal Guardian Name

_____, and hereby give authorization for
Patient Name

_____, to be involved in all aspects of patient
Individual Named

care for the patient named above at the Haymount Institute for Psychological Services, including but not necessarily limited to participation in therapy, exchange of information, and treatment planning. I understand that this authorization will be in full effect until I deem that I no longer wish for the individual named to be involved in the care of the patient, at which point I will provide a written statement retracting this authorization.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Date

PTID: RECEIPTENTID: RECORD#: