THE CENTER for mental health
providing help, hope and healing

MINOR SERVICES AUTHORIZATION FORM

I hereby authorize The Center for Mental Health to provide mental health and/or substance abuse services to the following minor child:

_____ _____

Child's Name Date of Birth

By signing this authorization, I understand that I may not request access to the minor child's Records in connection with any action involving a determination of the best interests of the minor child because the minor child has a right to privileged and confidential communications in relation to that type of legal action. I understand that the Center will not release the minor child's records in relation to that type of legal action. I understand that The Center will not release the minor child's records in relation to that type of legal proceeding unless a valid waiver of the minor child's privilege or court order is received by The Center.

If the minor child is fifteen years or older, the Center, and/or its employees, upon request from a parent or legal guardian, without the consent of the minor child, may advise the parent or legal guardian only of the services given or needed. Release of this information regarding services shall not be considered a waiver of the minor child's right to privileged and confidential communications or The Center's and its employee's duty of confidentiality.
I may request at any time that this authorization be revoked. In any event, the authorization expires when the case is closed. Expiration or revocation of this authorization does not waive any privilege.

_____ _____

Parent or Legal Guardian Date

_____ _____

Witness Date