EARLY CHILDHOOD *Wellness place*

520 Zang Street Ste 212; Broomfield, CO 80021

Email: **Julia@earlychildhoodwellnessplace.com**

Office Ph: 303-460-3881 Provider Ph: 720-588-3665

Consent for the Treatment of a Minor

I, (**Parents Name**)_____, hereby authorize **Julia Morrison, MSW Intern**

to provide mental health services to; (**Child's Name**) _____.

I attest that I am the **sole/joint (please circle one)** legal guardian of the above stated child and am legally and financially responsible for the above stated child. In the case of joint custody, both legal guardians are required to sign this consent form before a minor child can be seen in therapy. *When parents are divorced, Colorado law allows any parent who has been assigned parental responsibilities access to medical records. Therefore, in compliance with C.R.S. §14-10-123.8, you authorize me to provide access to treatment information to such an individual by authorizing me to provide services to a child in your custody.*
Legal documentation of the custody/guardianship agreement is needed at the time of signing this consent form and before the minor child is seen in therapy.

_____ _____
Signature of parent or legal guardian Date

_____ _____
Signature of parent or legal guardian (for joint custody) Date

_____ _____
Signature of Minor aged 12+ Date

_____ _____
Signature of provider (*indicating that legal* documentation has been *received*) Date