SAGE
RECOVERY & WELLNESS CENTER

Non- Parent/Guardian Authorization for Consent for Psychological Assessment & Treatment

I, _____, the parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named person(s) to consent to the medical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parent or legal guardian to sign for any and all psychological assessments or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all psychological assessments and treatments of said child(ren).

This authorization is for:

□ **Today's date only.**

□ **A specific date of: _____.**

□ **All future visits effective for one year from today's date.**

I realize that it is my duty to update and notify my physician's office of any necessary changes that must be made to this document within a timely manner. I also understand that to ensure this document is accurate I will be required to complete it annually.

_____	_____	_____
Signature	Relationship to child(ren)	Date

Child(ren):

_____	_____	_____
Name	Name	Name

Person(s) who are authorized to seek medical care for the child(ren) listed above:

_____	_____
Name	Relationship to the child(ren)
_____	_____
Name	Relationship to the child(ren)