Behavioral Health Providers, P.C.

Helping you through life's transitions

We will only use and disclose the following information for health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Please complete the following - All Information is required

Permission to Provide Mental Health Treatment to a Minor

I hereby grant my permission for my son/daughter, _____ to
(Name of minor)

be treated by Behavioral Health Providers. This permission will remain in force until revoked by me.

Signature Parent or Guardian: _____ Date: _____

Signature Witness: _____ Date: _____

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