Daniel S. Sokal, LCSW

Psychotherapy

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Authorization for Treatment of a Minor

Clinical Record Number:__________

I, ________________________________ the parent or legal guardian of

Parent/Guardian Name

__________________________________ , a minor hereby do authorize

Client Name **Date of Birth**

__________________________________, as an agent for myself

Agent Name **Telephone Number**

In my absence or incapacitation. This authorization will include but is not limited to Diagnosis, Treatment, and Therapy services. It is understood that this authorization is given in advance of any specific mental health and/or clinical intervention and is given to provide authority and power on part of the aforesaid agent to give specific consent to any and all mental health care which Daniel S. Sokal, LMSW deems advisable.

I hereby authorize Daniel S. Sokal, LMSW who has provided the treatment to release the above named minor into the physical custody of the above named agent upon completion of treatment.

This consent will be honored in the event the parent/guardian cannot accompany the minor child to appointments as scheduled. However, this authorization is no way emancipates the parent/guardian from any rights they currently have.

This authorization **shall remain effective for one (1) year from the signing date and can be revoked at any time by the parents/guardian and/ or the agent. Original form will be kept in patient's clinical record and copies will be distributed to the parents/guardian and the agent upon execution.**

__________________________________ __________________________________

Parents/Guardians (Please Print) Date **Witness Name (Please Print) Date**

__________________________________ __________________________________

Parent/Guardian Signature Date **Witness Signature Date**

- **Witness must be at least 18 years of age and a third party to this form**