Deborah Levi Lane, LCSW, PLLC

AUTHORIZATION FOR CLINICAL DECISION MAKING FOR A MINOR PATIENT

I strongly encourage a parent or legal guardian to be present with their children at all visits so that they may provide consent for treatment and accurate clinical history. In the event that this is not possible, you, as parent/legal guardian may authorize an adult to serve as proxy and fulfill this role on your absence. By signing this form, you are giving written consent for another adult to make clinical decisions for your child in your absence.

I, _____ as parent/legal guardian of minor patient: _____, authorize the following person(s) to make clinical decisions for the aforementioned minor in my absence:

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

_____ _____

Signature of Parent/Legal Guardian Date