Confirmation of Medical Decision Making for a Minor Child

Form must be completed for all persons seeking treatment age 17 or younger.

www.summitstonehealth.org

Please return completed form to SummitStone Health Partners Attn: Access Center
1250 N. Wilson Ave. Loveland, CO 80537 • Fax (970) 300-3118 • Phone: (970) 494-4200
SUMMITSTONE_ACCESS_CLINICIANS@SummitStonehealth.org

Client Name:_____ **Date of Birth:** _____

I,_____, state and attest that I may legally consent to medical, mental health and/or substance abuse treatment for the above listed minor child under the following authority:

- ☐ Self (at least 15 years old for any mental health or SUD services)
- ☐ Self (at least 12 years old for psychotherapy services rendered by a Title 12 C.R.S. mental health professional)
- ☐ Biological or Adoptive Parent
- ☐ Guardian/Legal Custodian/Other
- ☐ Department of Human Services (DHS)

Divorce Proceedings or Other Legal Proceedings

Have there been any legal proceedings or actions that have affected the decision-making authority regarding the minor child, including but not limited to: divorce proceeding, legal separation proceeding, paternity proceeding, termination or limitation of parental rights, or an assignment of legal custody/guardianship?

◯ Yes ◯ No

Documentation

The person signing this statement should attach documents verifying their legal authorityto make medical decisions for the minor child, unless the person signing is the child or if the person signing is the biological or adoptive parent of the child and there have been no legal proceedings or actions that have affected their decision-making authority regarding the minor child.

Parent/Guardian/Client Signature: _____Date: _____
Parent/Guardian/Client Print Name: _____
Relationship to the Child: _____

Parent/Guardian/Client Signature: _____Date: _____
Parent/Guardian/Client Print Name: _____
Relationship to the Child: _____

A signature is required for the information on this form to be considered valid.