



**AUTHORIZATION FOR TREATMENT - MINOR UNDER AGE 14**

In cases where the client is a minor, and there is a custody order issued by the court, our agency policy requires that you furnish us with a photocopy of your current Custody Order as it relates to the minor child. In family law matters, Joint (or Shared) Legal Custody can be awarded separate from Physical Custody. The Custody Order will typically state who has Legal Custody and who may make decisions about or consent to medical and/or mental health treatment. Orders specifically requiring shared medical and/or mental health decision-making will require the consent of both parties for the child to be seen by the therapist. If you need help determining your rights to obtain and authorize mental health treatment for your child, please contact your legal representative.

**Please complete EITHER Box A or Box B:**

**A**  **There is no current Custody Order regarding this child.**

I, \_\_\_\_\_, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc. I understand that participation in this program is voluntarily and I may revoke this consent at any time.

*By checking this box AND typing my name, I am verifying that this is my electronic signature*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**B**  **There is a current Custody Order regarding this child, and I agree to provide a copy of the Order to Jewish Family Service of Greater Harrisburg, Inc.**

Custody Order does not specify shared medical and/or mental health decision-making responsibilities.  
 I, \_\_\_\_\_, give my consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.  
*By checking this box AND typing my name, I am verifying that this is my electronic signature*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Custody Order specifies shared medical and/or mental health decision-making responsibilities  
 We, \_\_\_\_\_ and \_\_\_\_\_, give our consent for the above-named minor child to enter outpatient mental health treatment at Jewish Family Service of Greater Harrisburg, Inc.  
*By checking this box AND typing my name, I am verifying that this is my electronic signature*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date