3 Corporate Plaza Dr. Suite 140. Newport Beach, CA. 92660
Tel: (949) 642-7757 Fax: (949) 642-5091

LEGAL GUARDIAN/ REPRESENTATIVE'S AUTHORIZATION TO TREAT PATIENT

DEPENDENT/ CHILD/ MINOR (if applies: **guardin/ representative needs to sign**)

Patient Information:

Full Name of _____
(First) (Middle) (Last)

Date of Birth_____SS#_____

Address_____

_____
City State Zip

Legal Guardian/ Representative's Information:

Full Name_____
(First) (Middle) (Last)

Date of Birth_____SS#_____

Driver's License #_____

Address:_____

_____
City State Zip

I, _____am the Legal Guardian and/ or Legal Representative of the patient and on the patient's behalf I legally authorize Harbor Medical Associates, Inc.to deliver mental health care services to the patient. I also understand that all the Policies handed to me apply to the patient I represent.

_____
Legal Guardian/ Representative's Signature ***Date***