Crosspointe Family Services Consent to Treatment for Minors

Patient Name:D.O.B.Current Marital Status of Biological Parents: MarriedSeparatedDivorced

In accordance with Idaho Law, HIPAA, Idaho Bureau of Occupational Licenses and other entities, Crosspointe Family Services (CFS) is required to obtain consent to treat minor children ONLY from those individuals who are authorized to give consent legally. Additionally, CFS is required to make notification to the absent parent that their biological child(ren) is/are seeking and receiving mental health services at CFS.

- 1. I, the undersigned, hereby give consent for my minor child(ren) (patient name(s) above) to receive mental health services from Crosspointe Family Services.
- 2. I understand that I will provide an entire copy of Divorce Decree, Custody Agreement, Adoption, Foster Care and or Guardianship documents at time of application and prior to starting services.
- I understand that I am required to provide any known contact information for the ABSENT BIOLOGICAL PARENT in order for notification to that parent. ABSENT PARENT Name:______Phone: ______ ABSENT PARENT Address: ______City: _____State: _____
- 4. **Exception**: In situations where there is abuse or danger posed by the parent that has not brought the child in for treatment, Idaho law provides discretion to the provider to determine that, due to neglect or abuse, it should protect the confidentiality of the minor's information from the other parent.

CERTIFICATION: I/we certify that I am (please initial one):

- _____Birth Parent _____Adoptive Parent _____Legal Guardian
- Divorced Parent who has legal Custody
- _____Representative of Idaho H&W for Foster Care patient

I acknowledge that I have read, understand, signed, and received a copy (if desired) of the "*Consent to Treat for Minors*".

Authorized Individual Printed Name Signature

Date