Riverside University Health System – Behavioral Health

Child Consent for Treatment

I authorize _____ to participate in treatment provided by _____, on behalf of Riverside University Health System – Behavioral Health. This authorization requests and authorizes any necessary psychological and/or psychiatric evaluation and treatment. My signature below indicates that I agree and give consent to the above services. I also understand that parental participation in one or more of the following may be requested:

Assessment
Individual Counseling
Family Counseling
Parenting Skills Training or
Group Counseling

I understand that by authorizing treatment, personal health information may be exchanged in a limited way for treatment, payment and healthcare operations purposes, only.

Signature _____
(Check One) ☐ Parent ☐ Legal Guardian

Date _____

Print Name: _____

Witnessed: _____

Date: _____