Client Name

DOB

Provider

Date of Appointment

Confirmation of Medical Decision Making for a Minor

Form must be completed for all persons seeking treatment under the age of 18.

I, _____, state and attest that I have the legal decision-making authority to consent to medical, mental health, and/or substance use treatment at MHC Healthcare for the above listed minor as or under the following authority:

- ☐ Self (emancipated, mature minor)
- ☐ Biological or Adoptive Parent
- ☐ Department of Child Services (DCS)
- ☐ Guardian/Legal Custodian/Other

General Documentation

All persons signing this attestation shall provide MHC Healthcare the following documents verifying their legal authority to make medical decisions for the minor:

- ☐ Valid photo ID of the attesting adult
- ☐ Insurance card or policy containing name of minor (if utilizing private insurance)

Divorce or Other Legal Proceedings

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

☐ Yes ☐ No

Supporting Documentation (if 'Yes' above)

If there has been legal proceedings or actions that have affected the decision making authority regarding the minor, please provide the one of the following documents:

- ☐ Medical/Mental Health Care Power of Attorney
- ☐ Order Appointing Guardianship of Minor
- ☐ Emergency/Temporary Guardianship Order
- ☐ Divorce Decree with Legal Decision-Making Order*

*If Divorce Decree grants both parents legal decision-making authority or the equivalent as defined under A.R.S. 25-401, the consent of both parents, telephonic participation by the parent not present, or a signed authorization form is required during the intake/assessment or prior to rendering non-emergency care.

☐ Notice to Provider

☐ Decree of Emancipation

☐ Other (specify): _____

I, the medical decision maker of the above-mentioned patient, agree that the information indicated on this form is true and correct, and understand that any misrepresentation(s) or omission(s) selected or disclosed herein will create liability on behalf of the signatory and not MHC Healthcare, MHC Healthcare Behavioral Health, its staff or employees.

Print Name: _____

Signature: _____ Date: _____

Relationship to Minor: _____