Alepix Behavioral Clinic

MENTAL HEALTH SERVICES FOR ADULTS & CHILDREN
25 N. THOMPSON LANE, SUITE E, IRWIN, PA 15642
MAIN 724-382-4941 FAX 724-590-5121
www.alepix.com

TREATMENT DESIGNEE CONSENT
For Children Under the Age of 14

Patient Name: _____ Date of Birth:_____ Insurance ID:_____

It is the policy of Alepix Behavioral Clinic that all individuals under the age of 14 be accompanied by a parent or legal guardian. Alepix Behavioral Clinic recognizes that in some instances, a parent or legal guardian may not be available to accompany their child to treatment appointments. In such instances, the parent or legal guardian may provide consent to allow a designated adult to accompany their child to treatment appointments.

I understand that the individual(s) identified below will be treated by Alepix Behavioral Clinic as individuals involved directly in my child's care, and as such, Alepix Behavioral Clinic will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments, and all other functions normally associated with individual patient treatment, payment, and mental health care operations.

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

This document is an acknowledgement that the patient's legal guardian has supplied Alepix Behavioral Clinic with one or more contacts with whom they may use or disclose the patient's personal health information. Alepix Behavioral Clinic has made the treatment designee consent available to parents so that they may identify those individuals that could provide assistance in providing mental health treatment to children under the age of 14.

By signing below, I acknowledge that I have read and understand the above statements and accept the terms of this consent.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Alepix Representative Signature: _____ Date: _____

Copy Accepted___ Copy Refused: ___