GALE AND ASSOCIATES CENTER FOR ASSESSMENT AND PSYCHOTHERAPY PLLC
2760 WEST RASMUSSES ROAD SUITE 205
PARK CITY, UT 84098

CUSTODIAL PARENT DISCLOSURE

I, _____(legal guardian) attest that I am the sole legal guardian and custodial parent of _____(minor patient). I attest that I have full legal authority to give informed consent to my minor child's medical and psychological treatment, to authorize the release or exchange of confidential information pertaining to my child's treatment, or to deny release or exchange of confidential information based on my assessment of what is in my minor child's best interest. I attest that I can promptly furnish Gale and Associates, PLLC with legal documentation of my child's guardianship and custody status if such proof is deemed necessary to enroll my minor child in treatment.

By signing below, I attest that I have not intentionally provided Gale and Associates, PLLC with false information regarding my custodial rights or the current status of my minor child's guardianship.

Client _____Date _____Parent/Guardian _____Date_____

Witness_____ Date _____

I understand that it is the preference of my child's neuropsychologist/psychologist to have involvement from both the custodial and non-custodial parent in my minor child's treatment. This preference is in accord with the belief of Gale and Associates, PLLC that a more complete conceptualization of the minor patient's difficulties can be made when both parents have participated in the minor patient's treatment. By signing below, I attest that I acknowledge that my child's neuropsychologist/psychologist may prefer to consult with or to collaborate care with my child's non-custodial parent at some point in the evaluation/treatment process.

☐ I authorize Gale and Associates, PLLC to obtain_____, release_____, or exchange_____ (check one) specific information relative to the assessment/treatment of minor patient _____ with my minor child's non-custodial parent _____ (non-custodial parent's name).

☐ I DO NOT authorize Gale and Associates, PLLC to obtain, release, or exchange specific information relative to the assessment/treatment of minor patient _____ with my minor child's non-custodial parent.

Client _____Date _____Parent/Guardian _____Date_____

Witness_____ Date _____