

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 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 base on my assessment of what is in my minor child's best interest. I attest that I can promptly furnish Gale & 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 & Associates, PLLC with false information regarding my custodial rights or current status of my minor child's guardianship.

Name of Patient:

Name of Parent/Guardian:

Signature of Parent/Guardian:

Date:

Signature of Gale & Associates Rep.:

Date:

I understand that it is the preference of my child's neuropsychologist/psychologist to have involvement from both custodial and non-custodial parent in my minor child's treatment. This preference is an accord with the belief of Gale & Associates, PLLC that a more complete conceptualization of the minor patient's difficulties can be made when both parents have participated in the minor'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 & Associates, PLLC to **obtain** **release** or **exchange**
(check one) specific information relative to the assessment/treatment of the above mentioned, minor patient, with my minor child's non-custodial parent.

(non-custodial parent's name)

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

Name of Patient:

Name of Parent/Guardian:

Signature of Parent/Guardian:

Date:

Signature of Gale & Associates Rep.:

Date: