BAY AREA BEHAVIORAL SERVICES
135 North Moon Avenue
Brandon, Florida 33510

CONSENT FOR TREATMENT OF MINOR/DEPENDENT PERSON

I, (Responsible Party) _____, consent to the named minor/dependent person receiving clinical and therapeutic services at Bay Area Behavioral Services. My signature below authorizes Bay Area Behavioral Services to provide the below checked therapeutic services at the offices of Bay Area Behavioral Services.

Named Minor/Dependent Person: _____ Date of Birth: _____

☐ In-Depth Assessment
☐ Individual Therapy
☐ Family Therapy
☐ Group Therapy
☐ Treatment Plan
☐ Treatment Plan Updates
☐ CFARS/FARS
☐ Other_____
(Authorized Representative to check each box above)

Bay Area Behavioral Services will keep all information obtained through the clinical process in the strictest of confidence and will not release any confidential information gained through the therapeutic process to any persons without the prior authorization of the representative signing this form.

I understand that I may revoke this consent at any time by providing written notice, and that this consent automatically expires at time of discharge.

_____ _____
Signature of Client **Date**

_____ _____
Printed Name of Client **Date**

_____ _____
Witness Signature **Date**

_____ _____
Witness Printed Name **Date**