LEGAL GUARDIAN/ REPRESENTATIVE'S AUTHORIZATION TO TREAT PATIENT

DEPENDENT/CHILD/ MINOR (If applies please have the **guardian/representative sign)**

I am the legal guardian and/or Legal Representative of the patient and on the patient's behalf I legally authorize Harbor Medical Associates, Inc. to deliver mental health care services to the patient. I also understand that all policies described above apply to the patient I represent.

Name of Patient _____ DOB _____

Legal Guardian/Representative's Name_____

Legal Gurdian/ Representative's Signatures _____

Date _____