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I, _____, give my permission for my child, _____, to be treated by _____. I understand that I may come to any appointments for my child, and have the right to ask for treatment updates and/or appointment times for my child. I understand that I have the right to terminate treatment at any time. I understand that Atlantic Psych Associates is not responsible for coordinating the scheduling of appointments between my co-parent and myself.

I also understand that notifications and reminders of upcoming appointment times are the responsibility of my co-parent and myself and not that of Atlantic Psych Associates.

_____ _____
Signature Date

_____ _____
Witness Date