

**YOUTH DYNAMICS, INC.**

**CONSENT FORM**

As the parent / guardian of, \_\_\_\_\_, a minor child,

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Today's Date: \_\_\_\_\_

(Please **initial** the following):

\_\_\_\_\_ I hereby give my consent to Youth Dynamics, Inc. (YDI) and any other members of the Treatment Team so designated by YDI to render mental health treatment to the minor child named herein.

\_\_\_\_\_ I hereby give consent to YDI and any other members of the Treatment Team so designated by YDI to provide me with mental health treatment.

\_\_\_\_\_ I authorize YDI staff to provide transportation for the above named youth as deemed necessary by the Treatment Team throughout the course of treatment with the county of placement. (For GH, TFC, & TGC Programs: Client travel outside of the county of placement or state will require approval of placing agency or guardian.)

\_\_\_\_\_ I give permission to any available physician or member of hospital or medical staff to perform **emergency medical treatment and procedures** they deem necessary, and to continue treatment until such time as I dismiss him / her or engage another physician. This permission includes office visits, procedures, or admission to one of the local hospitals if the attending physician deems it necessary.

\_\_\_\_\_ I grant YDI the right to use my child's first name, age, photograph, art, written work, voice, verbal statements or portraits (video or still video) for marketing publications.

**For Out of Home Placement Services (in addition to the above):**

\_\_\_\_\_ I authorize YDI staff and YDI Treatment Foster Parents to arrange for and provide signatures for recreational activities provided by the school, church, or other organization for my child.

\_\_\_\_\_ I give permission to any available physician / dentist / orthodontist / optometrist, or member of hospital or medical staff to perform treatment and procedures they deem necessary, and to continue treatment until such time as I dismiss him / her or engage another physician / dentist / orthodontist / optometrist. This permission includes office visits or admission to one of the local hospitals if the attending physician deems it necessary.

\_\_\_\_\_ I give permission to any laboratory, testing center, or assessment center to conduct urinalysis screening procedures for drug / alcohol detection as deemed necessary by YDI staff.

*Information regarding the said treatment shall not be released to persons other than those employed by Youth Dynamics, Inc. (YDI) or to any members of a Treatment Team so designated by YDI, except as authorized in writing by me. I understand that there are circumstances under which YDI may be required by Montana law to disclose information without my express written authorization. If not revoked, this release is valid for a period of twenty-four months from the date it is signed.*

Printed Name of Parent / Guardian:

Printed Name of Witness:

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent / Guardian:

Signature of Witness:

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**Revocation: I hereby revoke the foregoing consent:**

Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_