

**EVALUATION AND TREATMENT OF A MINOR RELEASE**

As parent or legal guardian of \_

I authorize his/her diagnostic evaluation and treatment to include

individual counseling.

I have the right to request information concerning the above minor's

evaluation and treatment.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

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