



2209 E Market St
York, PA 17402
Phone: (717)759-1024

CONSENT TO TREAT A MINOR

As of January 1, 2026

Individual's name _____ DOB _____

SOLE LEGAL CUSTODY

By signing this form, I attest that I have sole legal custody of the above-named individual, and that there is no other parent or legal guardian who has the right to sign the information about the individual's medical treatment.

SIGNATURE _____ DATE _____

SHARED CUSTODIAL AND JOINT LEGAL CUSTODY PARENTS OR GUARDIANS

NAME: _____

NAME: _____

By signing this document, I/we have legal custody or shared custody of the named individual. I/we further consent to the treatment of the named individual. In the event of shared custody, the undersigned understand that both custodial parents or guardians have the right to access information regarding the treatment process and that wither has the power to release records with properly endorsed release of information.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____

NO CUSTODY

By signing this document, I attest that there is no custody agreement for the above-named individual.

SIGNATURE _____ DATE _____

*If the parent or guardian is not present to sign, a phone call and / or letter will be sent notifying of the consent of treatment.