PRA Perakis, Resis, Woods & Associates
PRA Behavioral LLC
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MINOR'S CONFIDENTIALITY AGREEMENT AGE 12-17

1. Professional Services
Parent and Provider agree that Child shall engage in behavioral health services with Provider, which may include, but not be limited to, outpatient psychotherapy, medication management, assessment/evaluation, and diagnosis.

2. Confidentiality
Parent's access to the Minor's mental health information with respect to the Services shall be solely limited to the following: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed, including medication, if any.

3. Not a Personal Representative
Parent agrees they shall not be considered a "personal representative" of Minor only with respect to the Services, with no general right to access Minor's mental health information relating to Services.

4. Voluntary Arrangement
Parent knowingly and voluntarily is waiving their general, contingent right to fully access Minor's mental health records and communications relating to the Services.

5. Revocation
Parent may revoke this Agreement, in writing, at any time. However, such revocation shall not apply retroactively to records and communications regarding Services already provided and shall not apply to the extent this Agreement has already been relied by Provider. Any such revocation shall be communicated to Minor.

6. No Waiver: Reservation of Rights
No waiver by Provider of any established legal right, or condition or provision of this Agreement, with respect to the confidentiality of Minor's mental health records and communications shall be deemed a waiver of any right, or provision or condition of this Agreement. This Agreement does not, in any way, restrict or impede Provider, Minor, or Parent from exercising any other applicable common law, statutory, or regulatory right relating to the Services.

By signing below, Parent assents and agrees to the limitation on access to mental health records and communications regarding the Services as described above. Parent acknowledges they have had the opportunity to ask any questions they may have had about this Agreement and Minor's confidentiality with respect to the Services, and any and all questions have been answered to Parent's satisfaction.

Patient Name: _____

Patient Signature (age 12 and older):

_____

Date: _____

Family Member/Responsible Party Signature:

_____

Date: _____

Family Member/Other Party Signature:

_____

Date: _____

Clinician Name:

_____