Washington law (RCW 71.34.530) permits minors age 13 and older to independently consent to outpatient mental health treatment. Children under 13 require parent or guardian consent. Complete ONLY the applicable section (Part A or Part B) below.

PATIENT INFORMATION

Minor's Full Legal Name	Date of Birth (MM/DD/YYYY)	Age	Grade / School

PART A: MINOR SELF-CONSENT (AGES 13–17) — RCW 71.34.530

Washington law allows a minor who is 13 years of age or older to request and receive outpatient mental health treatment without the consent of a parent or guardian. The treating provider may, but is not required to, inform the minor's parent or guardian of the treatment unless the minor objects and the provider determines disclosure is not in the minor's best interest.

Note regarding antipsychotic medications:
Under RCW 71.34.530 and WAC 246-341, minors retain the right to refuse antipsychotic medications except as ordered by a court. Medication prescribing will always involve a discussion of benefits, risks, and alternatives appropriate to the minor's developmental stage.

MINOR PATIENT SIGNATURE (ages 13–17):
I am 13 years of age or older. I voluntarily consent to outpatient mental health treatment at this practice. I have been given the opportunity to ask questions, and my questions have been answered. I understand I may withdraw this consent at any time.

Minor Patient Signature	Printed Name	Date
_____	_____	_____

Parent/Guardian Involvement (minor's choice — check one):

- ☐ I WANT my parent/guardian to be involved in my treatment
- ☐ I DO NOT want my parent/guardian notified of my treatment at this time
- ☐ I would like to involve my parent/guardian in some but not all aspects — I will discuss this with my provider

PART B: PARENT / GUARDIAN CONSENT FOR MINOR TREATMENT (UNDER 13, OR CO-CONSENT FOR AGES 13–17)

Parent or legal guardian consent is required for children under age 13. Parents/guardians of minors 13-17 may also sign as co-consenting parties if the minor has agreed to parental involvement in their care.

Parent / Guardian Full Name | Relationship to Minor | Phone

Parent / Guardian Address (if different from minor) | Email

Legal basis for consent (check one):

- ☐ Biological or adoptive parent with legal custody
- ☐ Legal guardian (attach court order if requested)
- ☐ Person authorized to consent under RCW 7.70.065 (e.g., foster parent, relative caregiver)
- ☐ Other legal authority:

Specify:

I am the parent, legal guardian, or authorized representative of the minor patient named above. I voluntarily consent to outpatient psychiatric and behavioral health evaluation and treatment for this minor at this practice. I understand that treatment may include psychiatric evaluation, psychotherapy, and/or medication management. I have had the opportunity to review the Informed Consent for Treatment form and ask questions. I understand I may withdraw this consent at any time.

Parent / Guardian Signature | Printed Name | Date

PART C: MINOR ASSENT (RECOMMENDED FOR ALL MINORS — NOT LEGALLY REQUIRED)

Although not required by law, we ask minors to provide assent (agreement) to treatment as part of our commitment to patient-centered, developmentally appropriate care. For young children, assent may be verbal and documented by the provider.

I understand (in my own words) that I will be coming here to talk about my feelings, thoughts, and behavior. I know I can ask questions. I agree to try this treatment.

Minor Assent Signature (optional for young children) | Printed Name | Date

For Provider Use — Custody / Consent Notes:

Custody documentation on file: Y / N Consent verified by: _____ Date: _____