



PERMISSION TO TREAT AND CUSTODY/GUARDIANSHIP STATEMENT

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LICENSED PSYCHOLOGIST

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Date: _____

Name of Patient: _____ **Date of Birth:** _____
(name of child or adult with guardian)

I certify that I am the patient, parent/guardian of the above-referenced individual and that I am fully entrusted to make medical decisions.

I authorize **Shrink Rap, Inc.** and/or designee to provide assessment, planning, treatment, referral and other related medical, educational, social, and psychological purposes with the identified patient.

CUSTODY and GUARDIANSHIP

If any split or shared custody, or shared guardianship agreement exists, I certify that I have notified all other guardians/parents of my intention to assessment, planning, treatment, referral and other related medical, neurocognitive, educational, social, and psychological purposes for the above-referenced individual.

1. *Printed Name of Authorized Signature*

1. **Authorized Signature**

Date

2. *Printed Name of Authorized Signature*

2. **Authorized Signature**

Date