Sunrise Therapy Services, LLC
580 Naugatuck Avenue
Milford CT 06461

Phone: 203-307-1123
Fax: 203-283-7714

Authorization To Treat A Minor (under 18)

I, _____, Parent/Legal guardian of _____

(Name of parent/legal guardian)

(Name of Child)

_____ give my permission for him/her to be seen at the Sunrise Therapy Services, for the purposes of (Date of Birth)

evaluation and treatment

_____
Signature of parent/legal guardian

Date

Witness Signature

Witness Name Printed