South Walnut Mental Health Services Program

BANGOR HEALTH CENTER
VAN BUREN COMMUNITY MENTAL HEALTH

AGREEMENT TO MODIFY/RESCIND SERVICES

Child Name: _____ **Date of Birth** _____

As the legal parent/guardian of the above-named minor, I am modifying/rescinding prior written consent for South Walnut Mental Health Services as follows:

☐ **Mental Health treatment is permitted only if I am contacted and I give approval for service delivery prior to my child being seen for every appointment/visit.**

☐ **No treatment or services shall be provided by South Walnut Mental Health services staff. Prior written consent is hereby rescinded for all services.**

My decision to modify and/or terminate services is due to the following reasons:

_____

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Parent/Legal Representative Signature and Date

Received by South Walnut Mental Health Services staff on:

_____

By: _____