<b>── 14€ 88 18011-D13C1C</b>	Sure Agreement	☐ Withdrawal of Non	-Disclosure Agreement
			ENTAL HEALTH CARE AGREEMEN
NOTICE OF NON-L	DISCLOSURE OF	WIINOR-INITIATED WI	ENTAL HEALTH CARE AGREEMEN
nsurance Plan: Kaisei	· Authorizations & Re	eferrals Management Fax	#: <u>808-432-5691</u>
Minor's Name:			
(Last na	ime)	(First Name)	(Middle Initial)
Minor's Date of Birth:		Minor's Kaiser Medical Re	ecord Number:
Minor's Street Address	s. City. State and Zin	Code:	
	,, city, ctate and E.p		
Minor's Signature <u>REQ</u>	<u>UIRED</u> :		
Mother's Name:		Date:	
or Legal Guardian	(Last name)	(First Name)	(Middle Initial)
Father's Name:			
or Legal Guardian	(Last name)	(First Name)	(Middle Initial)
		of age or older, may conse	nt to outpatient mental health services wi
Pursuant to §577-29, H parental or legal guard professional and there	RS, minors, 14 years ian consent, knowled is agreement on con	dge or participation, after confidentiality for minor initiat	
Pursuant to §577-29, H parental or legal guard professional and there I am hereby notifying t licensed mental health	RS, minors, 14 years ian consent, knowled is agreement on conhe minor's health plaprofessional which in	dge or participation, after confidentiality for minor initiated in that the above named mucluded a discussion on confident confident and confi	onsulting with a licensed mental health
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