

**Sylvia K. Neal, LCSW, PLLC**

**Psychotherapist**

**7360 N. La Cholla Boulevard**

**Tucson, Arizona 85741**

**(520) 219-1992 Fax: (678) 244-7858**

**Proof of Guardianship Form**

I, \_\_\_\_\_, swear that I am the custodial guardian of the child \_\_\_\_\_. Unless otherwise specified NO information, including but not limited to appointment information, medical records information, or any personal information shall be released to anyone other than the named guardian listed above.

This information is confidential and will be treated with respect. If at any time you wish to release information to anyone, including yourself, you will be required to sign a written release of information. Please be aware that Arizona law permits non-custodial parents access to their child's mental health records.

Please be aware that supplying our facility with factious or misleading information is a felonious act and will be treated as such.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Child's Full Name**

\_\_\_\_\_  
**Parent or Guardian**

\_\_\_\_\_  
**Witnessed by**