



Parental Consent Form
Mental Health Association of Southeastern Pennsylvania
Parental Notice/Consent Form
www.mhasp.org

This Web site wished to obtain personal information about your child, in order to provide requested services to your child or allow your child to participate in a survey or contest or submit a story. We do not intend to disclose this information to any third parties, except as provided by law. However, your consent is required for the collection of this information.

Please review, print out and complete the information below. Sign your name at the bottom of the form and fax or mail to us at Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Philadelphia, PA 19107. If you have any questions, please call us at 215-751-1800 x 215. If you are unable to print this form for whatever reason, please call or email us at (wkrum@mhasp.org) and request that a form be sent to you.

I, _____, (Parent or Guardian's name) hereby certify that I am the parent/ lawful guardian of _____.(child's full name).

Consent

I understand and agree that in order to _____ (purpose of consent), at Mental Health Association of Southeastern Pennsylvania (MHASP) or its affiliated organizations may collect the following personally identifiable information about my child, from my child: Full Name; Address; Physical address/ mailing address; Telephone Number; E-Mail Address; Birthdate; Sex; Other: _____.

This information will be maintained by MHASP until deleted by them or amended or deleted by me.

I also understand and agree that this information may be disclosed by MHASP to third parties if MHASP has good faith reason to believe that disclosure is reasonably necessary to comply with applicable law or to protect the interests of MHASP or its affiliates or others to which MHASP may have a duty to protect.

I have read and reviewed the MHASP Privacy Policy and the MHASP Children's Privacy Policy and voluntarily give this consent in accordance with the terms of those policies.

Request for Verification

_____ I request that you verify for me all the information about my child which you currently have. I have provided you with information below in order for you to verify my identity before you will release this information to me.

Request to Edit/Remove Information

____ I request that you make the following changes to the information you have about my child:

____ I request that you remove all of my child's information and I hereby revoke any consent previously given for you to obtain or use any personally identifiable information about my child.

Parent's Signature: _____

Printed Name: _____

Address: _____

City _____ State _____ Zip _____

Telephone Number: _____

Email Address: _____@_____

Mail or fax this form to :

Mental Health Association of Southeastern Pennsylvania
1211 Chestnut Street
Philadelphia, PA 19107
fax: 215-636-6300

or call or e-mail for questions or further information:
kids@mhasp.org
215-751-1800 ext 229