Touro University Nevada
Center for Autism and Developmental Disabilities

LEGAL CUSTODY AGREEMENT

Center for Autism and Developmental Disabilities

Patient Name: ____

Patient Date of Birth: ____

I, the undersigned, indicate by my signature below that I have legal custody of my child (named above), and, therefore, the right to seek evaluation and/or treatment for my child. I have been advised by Touro University Nevada Center for Autism and Developmental Disabilities that it is their recommendation that my child's other parent, if applicable, be informed of my decision to seek evaluation and/or treatment.

____	______________________
Printed Name – Parent or Legal Guardian	Date
____	______________________
Signature	Date
____	______________________
Signature of TUNCADD Witness	Date