Consent for Treatment of Minors

Case Name _____

Date of Birth _____

Counselor(s) _____

This is to certify that I give permission to Child & Family Consultants, Inc. and the counselor(s) above for treatment of my child. (Name of treatment facility here)

This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may include consultations with other associates of this institution.

This treatment may also include referrals to the other appropriate State and County professional agencies for further counseling.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

_____

Street Address

_____

City/State/Zip

_____

Phone

_____

Witness/Title