Katie Zezima McCabe, LCSW

Consent for Treatment

Client Name (s):_____

_____

_____

I am (we are) the sole guardian(s) for the client(s) listed above. By signing below, I (we) give informed consent and grant medical permission for Katie Zezima McCabe, LCSW to provide mental health evaluation and treatment for the clients listed above.

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____ Date:_____

Mental Health Provider Name:_____

Mental Health Provider Signature:_____ Date:_____

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