**Stacey J Nelson Ph.D.**

***Licensed Marriage Family Child Therapist***

1200 N. Federal Highway Suite# 200

Boca Raton FL 33432

[**drstacey@bellsouth.net**](mailto:drstacey@bellsouth.net) **561 859-7779**

**BILLING AND CORRESPONDENCE**

PO BOX 7052

Delray Beach FL 33482

**PARENTAL CONSENT FOR TREATMENT OF A MINOR CHILD**

I­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent) (Child)

Authorize Stacey J Nelson Ph.D. to provide treatment for my minor child. I understand all

Information will be strictly confidential as required by the laws of the state of Florida, and will not be shared with any persons or agencies (except for your insurance carrier) outside of this office unless the proper release forms have been signed.

I understand there are certain situations in which my Psychotherapist is required by law to reveal information to my insurance company, other persons including physicians, or other agencies without my permission. These situations include the threat of bodily harm to oneself or to another person, evidence or suspected child or elder abuse, or the issuance of a subpoena by a court of law.

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Parent’s name **(print) Father**  Date

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Parent’s name (Signature) Father Date

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Parent’s name **(print) Mother**  Date

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**Parent’s name (Signature) Mother Date**

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Witness Name Date

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Psychotherapist Stacey J Nelson Ph.D. Date