DRTHALIAMOSHOS
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FEIN# 83-1415619 • MT LICENSE# PSY-PSY-LIC-5075 • PA LICENSE# PS018579 • NPI# 1891353736

Consent for Treatment of Minor **(Client's age as determined by state law)**

Child's Name: _____ Child's Date of Birth: _____

I/We _____ am/are the legal guardian(s)

of _____ and give my/our permission to Dr. Thalia P. Moshos to provide psychological services to my/our child (children).

I understand that the therapy sessions will be confidential and that no information or records concerning those sessions will be divulged to any person, including parents or legal guardians, without the prior consent of the individual receiving services and this Psychologist or pursuant to state laws.

Authorization Option 1:

_____

Printed name and signature of Parent/Legal Guardian 1 Date

_____

Printed name and signature of Parent/Legal Guardian 2 Date

Authorization Option 2:

_____

Printed name and signature of Parent/Legal Guardian Date

_____ Copy of court order declaring sole decision-making powers is attached