



Child & Family Consultants, Inc.

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 _____