

MINOR CONSENT TO COUNSELING



As a parent or legal guardian of _____, I
(Child's Name)
authorize he/ she to be evaluated/ treated by _____.
(Therapist's Name)

As a parent or legal guardian, I have the right to request information concerning
the above minor's evaluation and treatment.

Child's Full Name _____

Child's Birth Date _____

Today's Date: _____

Signed: _____

Parent or Guardian
(Please circle one)

Witnessed: _____