CONSENT FOR THE MENTAL HEALTH TREATMENT OF A MINOR

Minor Name: _____ _____ _____

Last First Middle

Date of Birth: _____

Month / Day / Year

As the parent or legal guardian with the authority to consent on behalf of the minor named above, I hereby give my consent for the minor to seek counseling, psychotherapy, and/or psychiatric care as deemed advisable and/or necessary by

_____ _____

Provider Name Provider License

The provider above has explained to me the proposed treatment plan, the general nature and extent of the benefits and risks involved in the treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists (e.g., minor presents as a danger to self or other or reports being in danger). This consent is only for the services checked below and will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

Consent granted for:

- ☐ Individual psychotherapy
- ☐ Family psychotherapy
- ☐ Group psychotherapy
- ☐ Psychological testing
- ☐ Medication management

_____ _____ _____

Print Name of Parent/Guardian Signature of Parent/Guardian Date

_____ _____

Address (Street, City, State) of Parent/Guardian Phone # of Parent/Guardian