



CONSENT TO TREAT A MINOR

"Creating Life Balance Through Effective Solutions"

We, (Parents Names) _____ and _____, are legal custodial parents with decision-making responsibility for (Minor's Name) _____, a minor. (If sole legal custodian please attach a copy of Permanent Court Order Provision.)

We authorize Lisa Stull, MS, LMFT in her capacity as Licensed Marriage and Family Therapist to begin the mental health assessment and treatment of said minor on (Date) _____. Authorization will be in effect until such time as this psychotherapeutic relationship is terminated.

As legal custodial parent, we understand that we have the right to information concerning our minor child in therapy, except where otherwise stated by law. We also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. We therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us. This is my written consent to the mental health assessment and treatment of minor child under the terms stated above.

IF APPROPRIATE, PARENT WITH DECISION-MAKING RESPONSIBILITY FILL OUT AND SIGN THE FOLLOWING:

- I also authorize _____ to sign any and all papers necessary for client's treatment and to participate in treatment.
- I also authorize _____ to transport client to and from scheduled appointments.

Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal custodian (please attach provision).

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

Signature of Witness/Provider

Date

Lisa Stull, MS, LMFT

Phone: 303-905-9773 • Fax: 303-805-5513 • www.parkercounselingsolutions.com