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Parental Consent for Treatment of a Minor

Permission is hereby granted to Catherine M. Malkin, Ph.D., to provide outpatient mental health services as may be necessary to diagnose, treat, and care for the needs

of _____,
(child's name)
who is a minor and therefore under the care of his/her parent or legal guardian.

I understand that the therapist and I should clarify in the first session how and/or what information will be conveyed to me about my child or adolescent. I understand that under some circumstances, especially with adolescents, confidentiality may be crucial for the development of an effective therapeutic relationship. I further understand that any significant safety concerns regarding my child or adolescent will be brought to my attention.

This consent will be valid until the minor reaches 18 years of age, but can be revoked at any time by written notification.

I have read this consent form, and I certify that I understand its contents as of this date and time.

_____
Print Parent or Legal Guardian Name

_____
Parent or Legal Guardian Signature

_____
Relationship to minor client

_____
Witness Catherine M. Malkin, Ph.D.

_____
Date