Valentino Therapy Consent to Treat a Minor

PARENTAL OR LEGAL GUARDIAN CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

STUDENT/MINOR printed name: ____

Date of Birth: _____________ *Minor's Phone* _________________________________

As the parent or legal guardian with the authority to consent on behalf of the minor student named above, I hereby give my consent for the minor to seek counseling, psychotherapy, and/or referred psychiatric care as deemed advisable and/or necessary by Sharon Valentino, Licensed Marriage and Family Therapist. This consent will be valid until the minor student reaches the age of 18, but can be revoked at any time by written notification.

______________________	______________________	____________
Print Name of Parent/Guardian	*Signature of Parent/Guardian*	*Date*
______________________	______________________	____________
Print Name of Parent/Guardian	*Signature of Parent/Guardian*	*Date*

*Parent/Guardian Contact Information, address and phone numbers:*________________

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In order for your son or daughter to receive services, you must also:
Review and sign the Valentino Therapy Information and Consent Form.

CONFIDENTIAL