Connection Counseling
SERVICES
Reconnecting Lives, Restoring Futures

PARENTAL/GUARDIAN CONSENT FOR TREATMENT OF A MINOR

Re: _____ Date of Birth: _____
Last Name First Middle

I certify that I am the (father, mother, managing, conservator, legal guardian (circle one) of the above-named child, and I hereby give my authorization and informed consent for the above-named child to receive psychological or therapeutic outpatient diagnostic and treatment services from Christopher R. Merrell, Ed.D., LPC. I further certify that I have the legal authority to authorize and consent to this treatment (Documentation may be required i.e., Divorce, Decree, Guardianship, etc.…).

_____ _____
Date Legally Authorized Signature

_____
Printed Name

_____
Street Address

_____
City State Zip

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