

Consent to Treat a Minor

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 Tracy Brodrick, MA, LPC in her capacity as a Licensed Professional Counselor
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.

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