COGNITIVE THERAPY ORANGE COUNTY

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Parent/Legal Guardian Consent to Treat Minors

I hereby authorize,_____ , to provide services to my
(Licensed clinician's name and CA license number)

child _____.
(Minor's full name - printed *date of birth, DOB)*

Provided service include, psychological treatment and counseling services as directed by licensed clinician.

This form is an addendum to the **Psychological Services and Informed Consent** form, to authorize treatment of your child.

I understand this consent form and that I have a right to receive a copy of it, if I so request. I, the undersigned, am legally authorized to provide consent.

_____ _____

Signature of Parent/Legal Guardian *Date*

_____

Relationship to Child