CARAMENICO
COUNSELING GROUP, LLC

Parental Consent for Mental Health Treatment

Child's Name: _____ D.O.B.: _____

Therapist's Name and Credentials: _____

I, _____, ☐mother ☐ father ☐ _____,

give _____ permission to provide outpatient mental health treatment to my child _____.

I understand that I can rescind my consent in writing at any time. Such correspondence will be sent to Caramenico Counseling Group, LLC in care of the therapist providing counseling to my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist's Signature Name Date

☐ My signature attests that I have sole legal and physical custody or guardianship of this child. Per Court Ordered and/or Custody Agreement I am able to make medical decisions for this child without consent from any other individual.

_____
Initials/Date

☐ Copy of Court Order or Custody Agreement provided
☐ No Copy of Court Order or Custody Agreement provided. Explain: _____

_____
_____
_____