***![C:\Users\Latonia\AppData\Local\Temp\Temp1_merrellcr5-counseling_FINAL_230512[1].zip\merrellcr5-counseling_FINAL_230512\merrellcr5-counseling_final_230512.gif]()***

**CONSENT FOR TREATMENT OF MINOR CHILD**

Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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, M.A., L.P.C. 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