

CONSENT TO TREAT MINOR CHILD*-PARENT/GUARDIAN AUTHORIZATION

Patient/Child Name:

Local Address:

City: _____ State: _____ Zip Code: _____

Child Cell (if applicable): _____ Email (if applicable): _____

Date of Birth: _____ Social Security Number: _____-_____-_____

Parent/Guardian Complete the Following:

I grant Annie Murrell, MS, LPC permission to provide counseling psychotherapy for my child.

Parent/Guardian
(Print)

Relationship to Student

Parent/Guardian
(Signature)

Date

Parent/Guardian Contact Information:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: H _____ W _____ Cell _____

Is there anything further you would like for me to know before I meet with your child? Please include any additional details in the space below:

*A minor is defined as any patient who is under the age of 18.