

**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 Contact Information:**

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Email: \_\_\_\_\_

**Person Responsible for Payment (if different from above):**

Name: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Parent/Legal Guardian Complete the Following:**

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

Parent/Guardian  
(Print)

Relationship to Student

Parent/Guardian  
(Signature)

Date

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