Scott M. Williams, PhD, LMFT (MFT 19241)

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Parental Consent for Treating a Minor

I, _____, give my permission
Name of Parent or guardian of child

for my child, _____, _____,
Full Name of Minor Birth Date of Minor

to be treated and/or evaluated by Scott M. Williams, PhD, LMFT in psychotherapy. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____.
Date consent expires

_____
Parent or guardian's signature Relationship to minor Today's Date

_____
Name and Address of Parent or guardian (Street, City, State and Zip)

_____
Other parent or guardian's signature Relationship to minor Today's Date

_____
Name and Address of other parent or guardian (Street, City, State and Zip)

_____
Address of minor (Street, City, State and Zip)