LifeSpring Center

Mission Valley • Carlsbad • Rancho Bernardo • Webster
619-298-8722 ~ Fax 619-298-5235

CONSENT FOR TREATMENT FOR MINOR(S)

I, _____, give my consent that
(Parent)
_____ will be conducting psychotherapy
(Therapist)
with _____
(Child)
My relationship to the client: _____

I was notified that the holder of the privilege is _____

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept the psychotherapist's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

_____	_____	_____	_____
Name (please print)	Relationship	Signature	Date
_____	_____	_____	_____
Name (please print)	Relationship	Signature	Date