Consent for Treatment of Minors

Client Name _____

Date of Birth _____

This is to certify that I give permission to Stacey Laves-Khalifa, LPC for the psychological treatment of my child.
This treatment may include individual or group psychotherapy, counseling and testing. This may also include consultations with other associates in the institution.
I further certify that I have the legal authority to authorize and consent to this evaluation and /or treatment as parent(s), managing conservator, or guardian(s) of above stated client.
The treatment may also include referrals to other appropriate professional agencies for further counseling.

Signature of parent or guardian _____ Date _____

Printed name of parent or guardian _____

Address _____

City_____ Zip_____

Home Phone _____ Email _____

Witness/Title _____