Transitioning Families™
Creating Protected Spaces

Revised 2/17

Consent for Treatment of Minor

CONSENT FOR TREATMENT OF MINOR:

The undersigned person and/or responsible party hereby authorizes and requests that the Transitioning Families Treatment Team provide counseling/psychotherapyreunification services to_____ (Name of minor child). I understand that the policies of Transitioning Families will apply. I also understand that I have the right to ask questions about procedures used during the course of treatment and that the customary approach and methods will be explained upon request. This agreement may be revoked by me at any time.

_____
Signature of Parent/Legal Guardian. Date

_____
Signature of Parent/Legal Guardian Date

_____
Signature of Minor Date

_____
Signature of Therapist Date