LEGACY
MENTAL HEALTH CENTER

Permission to Treat Minors

I give permission to Legacy Mental Health to provide psychological services to my minor child.

These services are to include:

- Individual therapeutic services _____ Yes _____ No
- Parent/Guardian consultation _____ Yes _____ No
- Psychological evaluation and assessment _____ Yes _____ No
- Collateral contacts _____ Yes _____ No
- Report Writing _____ Yes _____ No
- Other _____

I understand that the specific content of the sessions between my child and the clinician will remain private, and that my child has the right to request that all information about his or her treatment not be shared with me.

_____ _____

Signature of Guardian **Date**

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