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