AUTHORIZATION TO TREAT MINORS

This form is required to schedule if parents are not married and share custody of a minor child

Today's Date: _____

Name of Minor Child: _____

Current Address of Minor Child: _____

_____

Mother's Name: _____

Father's Name: _____

I, _____, mother of minor child, agree to allow my child, _____ to be treated at Lake House Counseling, PLLC and receive counseling.

Each parent understands that this form indicates that they have the authority as indicated in their custody orders or as parents with custody issues, to sign this form and give legal permission to allow mental health counseling for the minor child.

_____

Signature of Parent/Date

_____

Signature of Parent/Date