Gabrielle Carey, Ph.D., LMFT

Permission to Treat Minor Children

Date: _____

I _____ give my permission
Parent/Guardian Name

to _____ to treat my minor
Therapist Name

Child/children:

_____

_____

_____

_____

with family therapy, play therapy, and/or individual therapy. I understand that I can revoke permission at any time.

Signature of Parent/Guardian _____

Signature of Therapist _____