



Elizabeth Ramirez Child & Family
Counseling, Inc.
www.elizabethramirezmf.com

Permission to Participate in Psychotherapy Minor

Name of minor: _____ Birth date: _____

I, _____ am the legal custodian of the above-named minor.
parent name, print

I understand the agreement for payment of services is made between myself and the therapist.

I understand the limits of privacy and confidentiality for the youth mentioned above while participating in psychotherapy.

Please check one:

- There is no difference in custody. There is no separation or divorce between the parents of this child
- I have full legal custody to consent to treatment of the minor without obtaining consent or approval of another person. *Please share documentation with therapist.*
- I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person. *Please share documentation with therapist.*

I understand my child may only receive psychotherapy services with my consent. I hereby give consent for *(child's name)* _____ to receive mental health services from Elizabeth L. Ramirez, MFT. *I am aware there is no reason why my consent is not sufficient.*

Parent/Legal Guardian Signature

Date

Parent/Legal Guardian Signature

Date

Psychotherapist Signature

Date