



## Permission to Participate in Psychotherapy Minor

Name of minor: \_\_\_\_\_

Birth date: \_\_\_\_\_

I, \_\_\_\_\_ am the legal custodian of the above-named minor.

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. Ramírez, 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