Community Family Therapy- Maria Mishkind, CA License LCS 238-17

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**PARENTAL CONSENT FOR TREATMENT OF A MINOR**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

give my consent for him/her to participate in psychotherapy with Maria Mishkind, LCSW.

I understand that his/her rights to confidentiality will be respected and that I will be informed of any information necessary to protect or enhance the therapeutic process.

This consent is subject to revocation in writing by the undersigned at any time except to the extent that action has been taken in reliance hereon. Otherwise, the termination of this consent will be on the same date as the termination of the therapy.

Signature of parent or legal guardian

Signature of minor if over 12

Signature of therapist

Date

Date

Date