SUDA CENTERS, INC.

CONSENT TO TREAT A MINOR

I/We, _____ (and _____), am/are the legal custodial parent(s) with decision-making responsibility for _____, a minor. (If sole legal custodian via court order, please provide a copy of permanent court order provision)

I/We authorize (name of therapist)_____, license #_____, in his/her capacity as a licensed psychotherapist to begin the mental health assessment and treatment of said minor on (date) _____. Authorization will be in effect until such time as the therapeutic relationship is terminated.

As legal custodial parent(s), I/we understand that we have the right to information regarding our minor child in therapy, except where otherwise stated by law. We also understand that minors are entitled to the same confidentiality granted to adults in therapy, and the therapist will provide the minor with a private environment in which he/she can fully disclose any issues that contribute to the child seeking therapy, even when initiated by the parents/guardians. With the above considerations, we give permission to this therapist to use his discretion, in accordance with professional ethics and laws relating to the practice of therapy, in deciding what information will (or will not) be shared with parents/guardians. By signing this document, we are consenting to the mental health assessment and treatment of said minor.

Signatures required from both parents unless treatment is court ordered and/or one parent is sole legal guardian.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Date