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Consent to Treatment of Minor(s)

Child's Name_____DOB_____ Age_____
Therapist___Aurora Mandy LMFT #47273

Instructions: Completion of items 1-8 and the signing of the affidavit are sufficient to authorize treatment services.

1. The minor named above lives [ ] in my home, [ ] in a _____ facility, and I am 18 years of age or older.

2. My name (adult giving authorization):_____.

3. My address is_____.

4. The address where the minor resides (if different):

_____.

5. My phone number is_____ Cell Phone:_____

6. I am the:_____

[ ] Parent of the minor listed above.

[ ] Grand parent, aunt, uncle , or other qualified relative of the minor listed above.

[ ] (Relationship to the minor)_____

7. Check one or both (for example, if one parent was advised and the other cannot be located)

[ ] I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize mental health treatment, and have received no objection.

[ ] I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

8. My date of birth is_____

9. My California driver's license or identification card number is:_____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment or both.

I declare under penalty of perjury under the laws of the State of California that the forgoing is true and correct.

Date_____
Signed_____

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