CROSSROADS

COUNSELING AND CONSULTATION

Consent for Psychological Services for Minor

Name of Person Giving Consent:_____

Your Relationship to Child (check one):

☐ Parent ☐ Stepparent ☐ Grandparent
☐ Guardian ☐ Other:_____

Name of Child:_____ Date of Birth:_____

I, _____, consent to the following

psychological/psychiatric services for the child named above:

Check and Initial All That Apply

☐ Clinical Interview/Evaluation
☐ Counseling/Psychotherapy
☐ Psychopharacotherapy
☐ Psychological Testing
☐ Psychiatric Evaluation
☐ Other _____

_____ _____
Signature of person giving consent Date

_____ _____
Signature of person giving consent Date

_____ _____
Signature of Witness Date