PERMISSION TO TREAT A MINOR

Minor client: _____

Parent/Legal Guardian:_____

I, _____ give permission to/authorize Kristina Schasker, M.A.,MFT
(Parent/legal guardian)
to assess, diagnose, and treat my child _____ in psychotherapy.
(Minor client)

I understand that confidentiality is an essential part of the relationship my child has with his/her therapist. I agree to respect that relationship and the limits of it. If I have questions or concerns about my child or his/her participation in therapy, I agree to contact the therapist myself and request a joint session with my child.

Should I decide to terminate treatment for my child for any reason, I agree to notify the therapist in advance and, unless otherwise indicated, allow my child an additional session(s) to discuss the progress made thus far, the significance of the relationship and its ending.

_____

Signature of Parent/Legal Guardian Date