COMMUNITY **C**OUNSELING **A**SSOCIATES
1506 N. Greenville Ave, Suite 200
Allen, Texas 75002
214-509-6888 Fax 214-509-6887

Consent for Treatment of Minor Dependent

RE: _____ BIRTHDATE: _____
LAST NAME, FIRST MIDDLE

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child. I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from the staff of Community Counseling Associates. I further certify that I have full legal authority to authorize and consent to this evaluation and/or treatment.

Date: _____

Father: _____
(signature)

or

Mother: _____
(signature)

or

Managing Conservator: _____
(signature)

or

Legal Guardian: _____
(signature)

Print Name: _____

Address: _____

_____

_____

_____