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## AUTHORIZATION TO TREAT A MINOR

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I/We, \_\_\_\_\_,  
Print name(s)

the Parents and Legal Guardians of \_\_\_\_\_,  
Print name

hereby authorize Melanie S. Rich, Ph.D. to provide psychological treatment to my/our minor child named above whose birthday is \_\_\_\_\_.  
mm/dd/yyyy

I/We understand that Dr. Rich may meet with my/our minor child individually during a session when I/we am/are not present.

I/We understand that Dr. Rich may discuss some issues with my/our child that are considered confidential.

I/We understand that Dr. Rich will inform me/us about any matters pertaining to the minor hurting himself or herself or anyone else, and the counselor may be required by law to report suspected child abuse or neglect to the proper authorities.

I/We also acknowledge receipt of a copy of the Notice of Privacy Practices.

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Mother or Guardian signature

Date (mm/dd/yyyy)

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Father or Guardian signature

Date (mm/dd/yyyy)