MELANIE S. RICH, PHD, LLC
Licensed Clinical Psychologist

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# AUTHORIZATION TO TREAT A MINOR

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 _____/_____/_____.

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.

_____

Mother or Guardian signature Date

_____

Father or Guardian signature Date