DEBALZO, ELGUDIN, LEVINE, RISEN LLC

CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Name: ________________________________ DOB: _____________________

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care including medication from the professional staff associated with or employed by DeBalzo, Elgudin, Levine, Risen LLC.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

___________________________ ______________________
Parent/Legal Guardian's Signature Relationship to patient

___________________________ ______________________
Address Phone

___________________________ ______________________
City Zip

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Date