**Break Thru Counseling Center**
**4012 Katella Ave., Suite 205**
**Los Alamitos, CA 90720**
**(562)431-1799**

## Consent to Treat a Minor

Date_______________

Child's Name:__________________________ Birth Date:_________

Address:_________________________________________________

_________________________________________________

I, the undersigned, (check the applicable statement)

_________ One of the parents having legal custody
_________ Both of the parents having legal custody
_________ The only parent having legal custody
_________ The person having legal custody

Of ______________________________a minor, do herby authorize

_________________________________, a counselor at Break Thru

Counseling Center, to provide psychological treatment to said minor.

This authorization shall remain in effect until termination of therapeutic duty unless person having legal custody of said minor revokes the authorization in writing before that date.

_____________________________________ _________________
Name of Parent/Legal Guardian (print) Date

_____________________________________ _________________
Signature of Parent/Guardian Date

_____________________________________ _________________
Signature of Parent/Guardian Date