Consent for Treatment of Minor

Child's Name: ____

Address: ____

City: _______________*State:* _____________ *Zip:* ___________ *Date of Birth:* ____________

Legal Parent/Guardian: ____

By my signature below, I confirm that I am the legal custodial parent/guardian of the aforementioned child. I confirm that I have the legal right to enroll my child in mental health treatment. I give my permission for Mosaic Counseling Services to treat my child. I understand that this permission will remain in effect during the duration of my child's counseling services or until revoked by me I writing.

______________________________	____________________________	_______________________
Printed Name of Client	Signature of Client	Date
______________________________	____________________________	_______________________
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
______________________________	____________________________	_______________________
Printed Name of Counselor	Signature of Counselor	Date