CONSENT TO TREAT MINOR CHILDREN

Please print all information:
Parent/ Legal Guardian 1:
I, _____, parent or legal guardian of _____, born_____, do hereby consent to mental health services by Victoria Valdez.

Parent/Legal Guardian 2:
I, _____, parent or legal guardian of _____, born_____, do hereby consent to mental health services by Victoria Valdez.

Therapist:
Victoria Valdez M.MFT
(931)-674-1205
7105 Peach Court, Suite 103
Brentwood, TN 37027
victoriavaldezmft@gmail.com

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian

_____ _____
Witness Signature Witness Name (please print)

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address _____
Telephone: Father _____ home _____ work_____
Mother _____ home _____ work_____
Child's Birthdate _____
Allergies to drugs or foods _____
_____