South Coast Psychological Services

Parent/Legal Guardian Consent to Treat Minors

I hereby authorize Dr. Dimitra Takos, Licensed Clinical Psychologist PSY 29103, to provide services to my child _____

(Print Minor's Full Name) (Date of Birth)

Provided services include psychological treatment as directed by Dr. Takos.

This form is an addendum to the Informed Consent and Services Agreement form, to authorize treatment of your child. In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Takos' judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

I, the undersigned, am legally authorized to provide consent.

_____

Signature of Parent/Legal Guardian Date

_____

Relationship to Child