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AUTHORIZATION TO TREAT A MINOR CHILD

_____
NAME OF CHILD

_____
DATE OF BIRTH

_____
NAME OF CUSTODIAL PARENT(S)

I warrant that I am a custodial parent of the above named minor child. I hereby give my permission for him/her to receive counseling from Angela Minor, Ph.D. I acknowledge that I am aware of the mandating reporting laws in the State of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility for notifying the child's other parent that counseling has been initiated and will take responsibility for arranging for the payment of all counseling services for my child.

Signed:_____Date:_____
Custodial Parent

Signed:_____Date:_____
Custodial Parent

Witness:_____Date:_____