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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 Myrna B. Vaughan, M.A. LPC. 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: \_\_\_\_\_