SUZANNE R. BENKO
Counseling for adolescents & adults

Consent for Treatment of Minors

Name of child _____

Age _____ Date of Birth _____

Mother _____ Father _____

If child does not live with both biological parents, where does other parent reside?

_____
Address Phone

Parental Consent for Treatment of a Minor

I am seeking psychotherapy for my child from Suzanne R. Benko, LMFT consistent with the provision of State Law AB657.

I understand that my child may not receive these services without my written consent.

I hereby give my consent for _____ to receive psychotherapy from Suzanne R. Benko, LMFT.

_____ Date_____
Parent/Legal Guardian

_____ Date_____
Parent/Legal Guardian

_____ Date_____
Witness

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