***Consent for Mental Health Treatment of Minors***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize that my child, (parent/legal guardian name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, may receive mental health treatment (child’s name)

provided by Thomas DiPaola, PsyD (Maryland License# 05491). I am aware that all custodial parents and legal guardians must give consent before treatment begins. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign a Consent for Mental Health Treatment Form before the child can be treated.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_