INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT
CONSENT FOR TREATMENT OF MINORS

Parent/Guardian Name(s): ______________________________________

This is to certify that I give my permission to Elizabeth Breitman, MA, LMFT-Associate for treatment of my child(ren). My/our signatures below affirms that I have the legal authority to consent for treatment of the child(ren) named below. If my legal guardianship is in any way directed by a court order, I agree to provide a copy to Ms. Breitman for her records. I agree to inform Ms. Breitman of custody and guardianship arrangements, and, if applicable, will inform the co-parent of the child(ren)'s participation in therapy.

I/we, the legal parent(s) or guardian(s) of the minor child(ren):

Child's Name: ___________________________ **Child's Date of Birth:___________________**

Child's Name: ___________________________ **Child's Date of Birth:___________________**

Child's Name: ___________________________ **Child's Date of Birth:___________________**

I/we grant my/our permission for any psychotherapy, testing, or diagnostic evaluation that Ms. Breitman may deem necessary in individual or family psychotherapy. I/we understand the potential for emotional discomfort and relationship changes not originally intended. I/we understand Ms. Breitman does not guarantee any particular results or outcome from the psychotherapy process.

Parent/Guardian Initials ___________

I/we understand and agree to the ICFE's confidentiality policies as detailed in the full consent form. These include the exceptions to confidentiality mandated by state law. These also include the possibility of sharing information disclosed in individual sessions, phone conversations, or written messages with those family members who have consented to treatment information.

Parent/Guardian Initials ___________

I/we understand the risks of psychotherapy as explained in the full consent form. I/we understand that Ms. Breitman does not provide emergency services and in the event of an emergency I/we agree to go to the nearest emergency room, call 9-1-1, or contact the Crisis Stabilization Unit of the Center for Health Care Services at 225-5481 (after hours 531-7826) or the United Way Help Hotline at 227-4357 (HELP).

Parent/Guardian Initials ___________

To be signed by a legal parent(s) or guardian(s):

______________________________ ________________________ ____________
Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

______________________________ ________________________ ____________
Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

__________________________________ ____________
Elizabeth Breitman, MA, LMFT-Associate **Date**