NARDINE AZAB, M.S, MFT

www.nardineazab.com

CONSENT TO TREAT A MINOR

Name of Minor Child: _____
Date of Birth: _____

In order for minor children/adolescents to receive mental health services, a parent/legal guardian must grant authorization for such services to occur.

By signing below, I certify that I am legally responsible for the above named child and am giving my permission for Nardine Azab, MFT to provide mental health treatment for my minor child, with or without me being present. This treatment may include individual/group therapy, consultation with other professional, crisis-intervention and referral services.

As the parent/legal guardian of the above named minor, you have the right to be included in the therapy process and to be kept informed of your child's progress in therapy. However, therapists must balance the parents' rights to be informed with the minor's right to privacy. As your child's therapist, I will use my professional judgment on these matters in adherence with ethical standards and state/federal laws. I will do my best to keep the parent/guardian involved and informed as deemed necessary.

Psychotherapy services are kept confidential and information shall not be released without a written authorization from the parent/legal guardian. However, California law mandates some exceptions to confidentiality; such instances include:

- *All suspected incidents of child, elder or dependent adult abuse.*
- *Imminent risk of harm to self or others.*
- *Court orders to release information*.

By signing below, I authorize Nardine Azab, MFT to treat my minor child according to the terms stated above. I also accept financial responsibility for payment of all fees associated with such services.

Name of parent/legal guardian #1:_____
Signature:_____
Relationship to minor:_____
Date:_____

Name of parent/legal guardian #2:_____
Signature:_____
Relationship:_____
Date:_____