6337 Hollister Drive
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INDY psych

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Consent for Treatment of a Minor

Child's Name: _____
Birth Date: _____
Address: _____
City / State: _____
Zip: _____
Phone: (___)_____

Parent or Guardian's Name: _____
Address (if different from child's):
_____
City / State: _____
Zip: _____
Phone: (___)_____

I confirm that I am the legal, custodial parent or guardian of the minor child named above. I give my permission for the psychological assessment and / or treatment by Dr. Dobbs and IndyPsych of this child. I understand that this permission will remain in effect during the duration of my child's services at IndyPsych or until revoked by me in writing.

Signed: _____ Date: _____

Witnessed: _____ Date: _____