

AUTHORIZATION FOR TREATMENT OF MINOR

I authorize \_\_\_\_\_ to participate in treatment provided by Dr. Tanya Mesirow. This authorization includes psychotherapy, assessment, evaluation, and testing. My signature below indicates that I agree to give consent for the treatment of my minor child. I also understand that parental participation may be requested.

Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Circle one: PARENT      LEGAL GUARDIAN