Consent for Services- Minor Client

Name of Minor_____DOB_____

(Please Print

School_____Grade____

I, _____give permission to Thomas Kessler

LMFT, RAS, to provide psychotherapy services, assessment, review medical and/or school records, and to consult with teachers and/or school counselors regarding the above named minor, if necessary.
This consent will remain effective one year from date of signing or one month after services have discontinued, if receiving services longer than one year.

_____	_____	_____
Parent or Legal Guardian (Please print)	**Signature**	**Date**

_____	_____	_____
Print	**Signature**	**Date**