Alison Freeman, Ph.D

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Consent by Parent/Legal Guardian for Minor to Receive Counseling/Psychotherapy Services

I/We the undersigned, ☐ parent, ☐ guardian or ☐ health care surrogate/proxy

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Parent/Legal Guardian Date

I hereby authorize Dr. Alison Freeman to provide treatment and/or assessment to my child/ren as specified below:

_____
Child's name

_____
Child's name

_____
Child's name

_____
Child's name

I understand that while my consent can be revoked orally or in writing at any time during treatment, that it would be best to express any concerns or grievances with Dr. Freeman so that there can be a reasonable amount of time for termination. _____

I have read and had this information fully explained to me and I have had the opportunity to ask questions and receive answers about the treatment. _____

I understand that Dr. Freeman will be working with my children and will not be serving in any legal capacity i.e. testimony during the process of divorce.

_____ _____
Signature Date

_____ _____
Therapist Signature Date