Angel House Bereavement Center

CONSENT TO TREATMENT OF A MINOR CHILD
ID # _____

NAME _____ DATE OF BIRTH _____

We, the undersigned, are the legal parents or guardians of the minor child (under the age of 18) referenced above and hereby authorize the staff of Angel House Bereavement Center to provide professional services to our child. We understand these services may include individual and family clinical interviews, assessments, consultations, and treatments that the clinical team considers to be in the best interest of our child. Services may also include discussions with other providers (e.g. the child's physician, teacher or guidance counselor) and communication with individuals who have a relationship with our child (e.g. other family members, stepparents, close friends.)

Parent/Guardian Printed Name _____ Date _____

Parent/Guardian Signature_____

Parent/Guardian Printed Name _____ Date _____

Parent/Guardian Signature_____

Witness Signature _____ Date _____