



Minor's Name: _____

Date of Birth: _____

This is to certify that I have the legal right to give and hereby give permission to Trinity Family Counseling Services for the treatment of my child.

This counseling may include individual or group psychotherapy, counseling, and testing. This counseling may include consultations with other associates of this organization.

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____

Witness Signature: _____ Date: _____

Witness Name: _____

Custody Documentation Required? ____ Yes ____ No

Custody Documentation Obtained? ____ Yes ____ No