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Toll Free: 888 996 9374 • Office: 440 392 2222 • Fax: 440 565 2349
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PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Child's Name: _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed by The Behavioral Wellness Group.

The mental health provider responsible for the care, _____,
(Clinician's Name)
Explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. However, treatment will be not delayed if any emergency exists. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

Any questions relating to this form or the proposed treatment can be directed to The Behavioral Wellness Group at 440-392-2222.

_____ _____
(Print Name of Parent/Guardian) (Signature of Parent/Guardian)

_____
(Date)