Dr. Janice Avalone, Psy.D., LMFT

Licensed Marriage & Family Therapist License # MFC 106305
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CONSENT TO TREAT A MINOR

I/WE _____, parent (s) or legal guardian(s) parent(s)/guardian(s)

of _____, a minor, hereby consent to (minor)

counseling services of minor by Dr. Janice Avalone, LMFT. I understand that children are entitled to a confidential relationship with their therapist, and I will respect that confidentiality.

SIGNED: _____
PRINT NAME: _____
Relationship to minor: _____(mother, father, legal guardian)

SIGNED: _____
PRINT NAME: _____
Relationship to minor: _____(mother, father, legal guardian)