GALLERIA COUNSELING & CONSULTING
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DEBORAH A. OLSON, M.A. LPC

PARENTAL CONSENT TO TREAT A MINOR CHILD

I, _____, hereby authorize Deborah A. Olson, M.A. LPC, to provide psychological services to my child, _____.
I certify that I am the legal parent/guardian of this child and have the legal right to authorize psychological services for the child. The specific psychological services I am authorizing Ms. Olson to provide my child include:

____Psychological Testing

____Personality/Emotional Assessment

____Individual Psychotherapy

____Family Therapy

I understand that in order to secure the trust and cooperation of my child, Ms. Olson may not divulge to me certain things my child shares with her. I do expect Ms. Olson to provide feedback to me about her impressions and any suggestions she has for me as a parent.

Signature of Parent

Date