CONSENT FORM: PARENT/CHILD

I _____ parent of _____ give MY consent to his Psychologist, _____ to discuss MY Mental Health status, as agreed with his/her Doctor/Psychiatrist.

I _____ parent of _____ also give consent to Marinda Reynecke to treat my child in therapy.

_____
Patient Signature

_____ _____
Mother Signature Father Signature

_____ _____
Psychologist Signature Date