

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



THERAPISTBOX
PSYCHOLOGIST / SIELKUNDIGE

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