



## Consent to Treatment (For Clients Under 14 Years of Age)

Client Name:	D.O.B.:
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I \_\_\_\_\_, father mother legal guardian, give Ravenhill Psychological Services permission to provide mental health treatment to my child \_\_\_\_\_. I understand that I can rescind this authorization at any time. I have also read and agree to Ravenhill's Informed Consent policy.

_____	_____	_____
Parent/Guardian Name (Print)	Parent Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name (Print)	Parent Guardian Signature	Date
_____	_____	_____
Provider Name	Provider Signature	Date