



the parent • child  
interaction center • LLC

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CONSENT FOR TREATMENT OF MINOR  
CERTIFICATION OF CUSTODIAL PARENT

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Therapist(s): \_\_\_\_\_

I verify that I am the custodial parent/legal guardian of this child/ren and I give permission to the PCIC staff, students, interns, clinic, and the therapist(s) listed above for treatment of my child. I also affirm that as custodial parent / legal guardian I have the legal right to consent to treatment. This treatment may include individual, family, or group psychotherapy, counseling, and testing. This treatment may include consultations with other associates of P-CIC. I agree to hold P-CIC harmless from or against any claim for compensation or harm resulting from the activities authorized by this agreement. This consent to treatment form is HIPAA compliant and can be revoked at any time.

\_\_\_\_\_  
Signature of Custodial Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Custodial Parent / Legal Guardian

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
P-CIC Staff Signature

\_\_\_\_\_  
Date