

Janice DeCovnick, Ph.D.
Licensed Clinical Psychologist - PSY7973
Licensed Marriage, Family, And Child Counselor - MFT17769

CONSENT FOR TREATMENT FOR MINOR/S

I _____

give my consent that **Janice DeCovnick, Ph.D.** will be conducting psychotherapy

with _____.

My relationship to the client: _____

I was notified that the holder of the privilege is _____.

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. DeCovnick's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

Name (print)	Relationship	Signature	Date
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