Katie Erreca, Psy.D.

www.DrKatieErreca.com

Clinical Psychologist PSY25101

Consent for Treatment of Minors

Minor's Information

Name: _____ Date of Birth: _____

School:_____ Grade:_____

This document certifies that I give permission to Katie Erreca, PsyD for the psychological treatment of my child. I understand that this treatment may include individual therapy, family therapy, or the administration of psychological testing.

In order to ensure a continuity of care, Dr. Erreca may request that you sign a release of information to consult with other professionals that are involved in your child's care including: Pediatricians, Educational Psychologists, Teachers, Nurses, or other School Personnel.

California state law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will be reported to the appropriate authorities.

If parents are divorced, please specify the custody arrangement: _____

_____

_____ _____

Print Name of Parent/Guardian with legal custody Signature of Parent/Guardian Date

_____ _____

Street Address Home Phone

_____ _____

City, State & Zip Cell Phone

_____ _____

Print Name of Parent/Guardian with legal custody Signature of Parent/Guardian Date

_____ _____

Street Address Home Phone

_____ _____

City, State & Zip Cell Phone

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