TriHealth

TRIHEALTH EAP

CONSENT TO TREAT A MINOR

I, _____, custodial parent/legal guardian of _____, age _____, authorize TRIHEALTH EAP to assess and treat my child in an outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s)/guardian(s).

Parent/Guardian Signature _____Date_____

Relationship _____

Witness _____Date_____