

PARENTAL CONSENT FOR THE MENTAL HEALTH TREATMENT OF A MINOR/STUDENT

Student/Minor: First _____ Last _____ Middle _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor student named above, I hereby give my consent for the minor to participate in counseling, psychotherapy, and/or medication services as deemed advisable and/or necessary by Dr. Alfredo Bimbela. Dr. Bimbela has explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

For questions related to the practice of psychologists and nurse practitioners:

California Board of Psychology: www.psychboard.gov

California Board of Nursing: www.rn.ca.gov

Name of parent/guardian

Address: _____

City: _____ State: _____ Zip Code: _____

Print Name of Parent/Guardian

Date

Signature of Parent/Guardian

Date