# Lazaro Counseling Center, LLC
# Consent for Treatment of a Minor Child

Child's Name:_____DOB:_____

I certify that I am the{**father, mother, managing conservator, legal guardian (circle one)**} of the above named child, and I hereby give my authorization and informed consent for the above named child to receive psychological treatment **/**services from P. Chauhan, Psy.D. I further certify that I have the legal authority to authorize and consent to this treatment.

_____
Legally Authorized Signature

_____
Relationship to child

_____
Printed Name

_____
Street Address

_____
City State Zip

_____
Date