Tammy L. Sausa, LCSW
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PERMISSION FOR TREATMENT OF MINOR

Client's Name: _____

Date of Birth:_____

Address:_____

School Currently Attending:_____

Parent / Legal Guardian:_____

I hereby consent and give my permission for _____, the minor mentioned above, to receive treatment with Tammy L. Sausa, LCSW.

I further certify that I have legal custody of this person and am in the position of being able to give such consent.

_____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Signature

_____ _____

Date of Consent Date of Consent