Farrow Psychological Services

9320 Carmel Mountain Road, Suite D
San Diego, California 92129

(858) 480-1484

CONSENT FOR TREATMENT FOR MINOR/S

I _____

give my consent that **Charles E. Farrow, Ph.D. (**therapist's name), will be conducting
□ psychotherapy □ neuropsychological evaluation

with _____

My relationship to the client (parent, uncle, etc.):

_____

I was notified that the person with legal custody is the holder of privilege. Usually this would be shared by the parents, but it may be a legal guardian. In the case of this minor the person(s) with legal custody is/are:

_____

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Farrow's (therapist's) judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

In no way do Dr. Farrow's services involve recommendations for custody.

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date