ANDREA DiFILIPPO, LICSW & ASSOCIATES
119 Wareham Road, Suite 104
Marion, MA 02738
(508) 748-3131

CONSENT TO TREATMENT OF A MINOR

MINOR'S NAME: _____

MINOR'S DOB: _____

I, _____, give my consent to Andrea DiFilippo, LICSW & Associates, to provide treatment and therapy necessary or advisable for my child. I understand that I may stop treatment at any time and that Andrea DiFilippo, LICSW & Associates, has the same right.

I realize that my child's treatment is confidential. Information may not be released without my written consent except in the event that an issue is raised which in the therapist's judgment, would endanger my child's welfare. I would be notified, as would appropriate authorities and resources, if indicated.

My child's therapist may determine with my child that my participation is needed to treat a specific problem.

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN

_____
SIGNATURE OF CHILD (IF INDICATED)

_____
WITNESS