Ana V. Cofresi, Ph.D., HSPP
70 E. 91st Street, Suite 201
Indianapolis, IN 46240
317-566-2812

CONSENT FOR TREATMENT OF MINOR (UNDER 18)

As your child's psychologist, it is important that your child is able to trust me completely. As the parent or guardian, you have the right and responsibility to question and understand the nature of my activities and progress with you child, but I must use my clinical discretion as to what is an appropriate disclosure.

Child's Name____
Date of Birth______________________________________

I am the legal custodial parent or guardian of the above named child and give my permission to **Dr. Ana V. Cofresi** to provide psychological services to my child. I understand the importance of my child's confidentiality and have had the opportunity to clarify my questions regarding this issue.

____________________________ ________________________________ ___________
Name Printed Signature of Parent/Guardian Date

____________________________ ________________________________ ___________
Name Printed Signature of Parent/Guardian Date