ELIZABETH ANN SMITH, L.C.S.W. A.C.S.W
ELIZBETH33@MSN.COM CELL: 480-294-4581

Date:

Consent to child/adolescent's clinical services/consultations

This letter given to me by Elizabeth Ann Smith, LCSW is to be understood as giving my full consent for my child/adolescent to be seen by her for clinical therapy services or consultation.

It is to be signed and dated by both parents with the name of the child/adolescent listed.

This acts as informed consent in joint custody parenting situations showing consent and understanding of both parents for their child prior to any treatment or consultation begins.

If you have any questions please ask the therapist before signing.

Thank you for your cooperation.

Sincerely,

Elizabeth A. Smith, LCSW

Child/adolescent full name:

Parents signatures consenting to therapy services:

Mother's signature: _____ Date: _____
Phone number: _____

Father's signature: _____ Date: _____
Phone number: _____