Kevin M. Harrington, Ph.D.
Licensed Psychologist
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612-766-9255 - 952-854-5062 FAX

CONSENT FOR TREATMENT OF A MINOR
(Ages 5-12)

I agree to therapeutic services provided to my minor by Kevin Harrington Ph. D. at this office

Clients Name:_____

Address:_____

_____

Parent(s)/Guardian(s) Signature

_____

Address (if different than client's address)

_____

Date:_____

I/We understand that I/we have the right to information concerning my minor child in therapy. Except where otherwise stated by law. (Minnesota Stat 144.341-324 except when the minor is married, legally emancipated or has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy related conditions. Minnesota Statute 144.335)

I also understand that this therapist believes in providing a minor with privacy in which to disclose her/himself to facilitate therapy/ I therefore give permission to this therapist to use his discretion with information revealed to my child in to be shared with me. (Minnesota Stature 144.335 subd2)

Parent(s)/Guardian(s) signature:_____

Date:_____