



HAWAII CENTER  
*for* PSYCHOLOGY

FINDING YOUR BALANCE

## CONSENT TO TREAT MINOR PATIENT

I, \_\_\_\_\_ (print name here), am the parent/legal guardian of \_\_\_\_\_ (print name of minor patient here), currently a minor, whose date of birth is \_\_\_\_/\_\_\_\_/\_\_\_\_.

\_\_\_\_\_ I share legal custody of patient with \_\_\_\_\_.

\_\_\_\_\_ I have sole legal custody.

I authorize Hawaii Center for Psychology (HCP) to provide mental health care to my son/daughter, including but not limited to diagnostic examinations and psychotherapy.

I understand that I may submit written notice to Hawaii Center for Psychology to rescind this consent. I further understand that once my child reaches the age of majority, my consent for treatment is no longer required (even if the process was initiated when my child was a minor).

By signing this, I acknowledge that I have read and that I understand this consent. I have had the opportunity to discuss this matter with HCP staff by phone or in person.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please provide phone numbers where HCP can contact you or leave messages via voicemail or with anyone who answers:

Primary Contact Number: \_\_\_\_\_

Secondary Contact Number: \_\_\_\_\_

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[HawaiiCenterforPsychology.com](http://HawaiiCenterforPsychology.com)