EAST LOUISVILLE PSYCHOLOGY GROUP, PLLC
1230 South Hurstbourne Parkway, Suite 245
Louisville, KY 40222

Permission to Treat a Minor

I authorize _____ to provide psychological evaluation and/or treatment to my minor child, _____.

I understand and accept what is discussed between the service-provider and my child will remain confidential between them, except when an issue of danger to my child or others is involved.

_____ _____
Signature of parent or guardian Date