MASSACHUSETTS
PSYCHIATRIC SERVICES, LLC

128 MAIN STREET, SUITE #3
STURBRIDGE, MA 01566
PHONE: (508)418-6888

CONSENT FOR PSYCHOLOGICAL SERVICES FOR A MINOR

NAME OF CHILD: _____ Date of Birth: _____

NAME OF PERSON(S) GIVING CONSENT: _____
(Please print clearly)

RELATIONSHIP TO CHILD:

❒ PARENT ❒ STEP-PARENT ❒ GRANDPARENT ❒ GUARDIAN ❒ OTHER: _____

We/I, the parent(s) and/or guardian(s) of a minor child named above give Massachusetts Psychiatric Services full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that Massachusetts Psychiatric Services are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability. I realize that at times the nature and/or content of such services must remain private. Therefore, I hereby release any right I may have to the information contained in the file of my son, daughter, or ward which may be generated as a result of such services.

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed by Massachusetts Psychiatric Services.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

_____ _____

Signature of person giving consent Date