Carol Cochrane Bass, M.A., L.M.F.T.

Santa Cruz Family Therapy, PC

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PARENTAL CONSENT FOR TREATMENT OF MINOR

I, _____as legal guardian of _____ ("Minor") give my consent for Minor to participate in counseling and psychotherapy with Carol Cochrane Bass, Licensed Marriage & Family Therapist (LMFT). I also understand that Minor's rights to confidentiality will be respected, and that I will only be informed of information deemed necessary by the Therapist to ensure the safety, of the Minor or to enhance the therapeutic process.

This consent is subject to revocation in writing by the undersigned at any time except to the extent that action has been taken in reliance hereon. Otherwise, the termination of this consent will be on the same date as the termination of the therapy.

Signature of person releasing confidentiality Date

Signature of minor Date