McAllister Psychiatry and Psychotherapy
Consent for Treatment
(for minors)

Client Name (s):_____

_____

_____

I am (we are) the sole guardian(s) for the client(s) listed above. By signing below, I (we) give informed consent and grant medical permission for Dr. Sarah McAllister and/or Dennis McAllister, LCSW, to provide mental health evaluation and treatment for the clients listed above.

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name (please print):_____

Parent/Guardian Signature:_____ Date:_____

Mental Health Provider Name:_____

Mental Health Provider Signature:_____ Date:_____

McAllister Psychiatry and Psychotherapy, LLC 69 East Avenue, Norwalk, CT 06851