Cassidy Erickson, LMFT
2095 W 6th Ave Ste 206 Broomfield, CO 80020
Phone 720-515-5227
Cassidy.S.Erickson@gmail.com

Consent for Treatment

I am the parent or legal guardian of the youth whose name appears below. By my signature below, I hereby authorize **Cassidy Erickson** to provide mental health treatment to my child. I understand that the services are intended to be confidential, subject to any legal reporting requirements, but that I may request information concerning my child from the therapist.*

_____	_____
Print Name of Parent or Legal Guardian	**Print** Name of Youth and Specify Age
_____	_____
Signature of Parent or Legal Guardian	**Signature** of Youth (if age 15 or older)
_____	_____
Date	Date

*As the parent or legal guardian, you may receive information about your child if they are under age 15. If the youth being seen is 15 years or older, then it is the child's right to release or withhold information regarding treatment.