ADVANCE THRU PSYCHOTHERAPY & FAMILY DEVELOPMENT, PA

Authorization to Treat a Minor Child

_____Tamara Sofair-Fisch, Ph.D. (NJ Lic Psychologist # 35S100165100**).**

_____Mark Sofair-Fisch, Ph.D. (NJ Lic Psychologist # 35S100432500;
NJ Lic Alcohol & Drug Counselor #37LC00043500).

I am the parent/ legal guardian of _____.

I authorize (circle one): TSF MSF to provide individual and/or family psychotherapy treatment for my child.

I agree that this therapist may hold in confidence things that my child may report to her/him. Content which may withhold from me may pertain to

- cigarette use,
- alcohol or drug use/abuse,
- sexual behavior,
- other at risk behaviors.

The therapist will not withhold any information that may be life threatening to the minor child or any other person.

If I choose to terminate this authorization, I must notify the therapist in writing.

_____(signature of parent/guardian)

_____Name and relationship to minor

_____(signature of parent/guardian)

_____Name and relationship to minor

_____(Signature of Minor)

_____Date

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