Kenneth F. Wise, Psy.D.
Clinical Psychologist
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Consent For Treatment of Minor Child

Re:_____ Birthdate: _____
Last Name First Middle

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above-named child, and I hereby give my authorization and informed consent for the above-named child to receive psychological or therapeutic outpatient diagnostic and treatment services from Kenneth F. Wise, Psy.D. I further certify that I have the legal authority to authorize consent to this treatment.

_____ _____
Date Legally Authorized Signature

Print Name:_____

Address: _____

_____

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