Diane Aukland, L.C.S.W.
Licensed Clinical Social Worker

CONSENT FOR TREATMENT OF A MINOR

Name of Minor _____ Age_____

Are you the legal guardian of this minor? Yes No

Are you the custodial parent of this minor? Yes No

Name any other person(s) who have rights as the legal guardian of this minor:

Name:_____

Address:_____

Phone Number:_____

I, _____, authorize Diane Aukland, L.C.S.W. to
(Name of legal guardian)

provide psychological assessment and treatment for _____.
(Name of minor)

Such treatment is limited to assessment and outpatient therapy. I understand that, under the provisions of California State Law, the codes of confidentiality and privilege will apply to all services provided.

_____ _____
(Signature of legal guardian) (Date)

42525 Rancho Mirage Lane, Rancho Mirage, Ca 92270
Appointment Desk: 760-898-2169 Fax: 760-832-8080 Confidential voice mail: 760-668-7665