Jean-Frederic Aboudarham, M.Eng., Ph.D.
Psychologist - License # PSY 16950
(650) 224-0085

CONSENT FOR TREATMENT (Minor/s)

I _____ (Parent or Guardian) give my consent that Dr. Aboudarham will be conducting psychotherapy with _____ (the Client). My relationship to the Client is: _____. I understand that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege (the Client).

I understand that the issues of trust and confidentiality between the Therapist and the Client are paramount to the success of therapy. Therefore, in the case of a minor Client, special sensitivity may be required in sharing information. I will accept the Therapist's decision regarding the release only of information pertaining to potential danger to the Client.

_____	_____	_____
Name (Print)	Signature	Date
_____	_____	_____
Name (Print)	Signature	Date