

**Honey A. Sheff, Ph.D., P.C.**

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**CONSENT FOR TREATMENT OF A MINOR CHILD**

We/I, \_\_\_\_\_, parent(s) and/or guardian(s) of the minor child(ren) \_\_\_\_\_, give Dr. Honey Sheff full and unconditional authority to proceed with a clinical evaluation and treatment as her judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child(ren). We/I have the legal power to consent to psychological and mental health assessment and treatment of said minor child(ren). It is clearly understood that Dr. Sheff is hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that her duties are performed with standard care and responsibility to the best of her professional ability.

\_\_\_\_\_  
Printed Name(s)

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature

\_\_\_\_\_  
Relationship to Child Client

\_\_\_\_\_  
Date

In cases of separation or divorce: I have provided legal documentation regarding conservatorship and my legal right to consent to treatment for my child and a copy of my divorce decree or current court orders. \_\_\_\_\_ (Parent Initial)