Tawnya S. Foster, Psy.D., LLC
Child & Adolescent Psychology
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614.947.0918 • 614.564.9416 fax • www.drtsfoster.com

CONSENT FORM

Permission is hereby granted to the clinicians of Tawnya S. Foster, Psy.D., LLC, Columbus, Ohio, to provide outpatient mental health services as may be necessary to diagnose, treat and care for the needs of _____, who is a minor and under
(child's name)
the care of his/her parent or legal guardian.

I understand that the therapist and I should clarify in the first session how and/or what information will be conveyed to me about my child/teen. I understand that under some circumstances, especially with teens, confidentiality may be crucial for the child/teen to establish a therapeutic relationship. I further understand that any safety concerns regarding my child/teen will be brought to my attention immediately.

I have read this consent form and I certify that I understand its contents as of this date and time.

_____
Parent or Guardian Signature

_____
Witness

_____
Date