

Julia Wall, M.Ed., L.P.C.

CONSENT FOR TREATMENT OF A MINOR

I, the undersigned _____ parent,
guardian of a minor _____, birth date
_____ give full and unconditional authority for Julia D. Wall,
M.Ed., L.P.C. to proceed with a clinical evaluation and treatment. This
consent is given by me a parent, guardian of said child. It is distinctly
understood that you are hereby fully released from any claims and
demands which may arise from the evaluation or treatment provided that
your duties are performed with ordinary care, professional responsibility
and to the best of your ability.

Parent/Guardian

Date

734 E. Corsicana Street
Suite B
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