DR. VICTORIA FITZGERALD, PLLC

214.295.7615

Consent for Treatment of Minor Dependent

Child: _____ Birthdate: _____
Last First Middle

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child. I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from Victoria Fitzgerald, Ph.D. I further certify that I have full legal authority to authorize and consent to this evaluation and/or treatment.

Father: _____ Date: _____
(Signature)

Or

Mother:_____ Date: _____
(Signature)

Or

Managing Conservator: _____ Date: _____
(Signature)

Or

Legal Guardian: _____ Date: _____
(Signature)

Print Name: _____