Springfield Psychological
Helping you find the right path.

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PARENTAL CONSENT FORM

I have been informed that a request has been made for my child/ren named below to receive treatment from Associates of Springfield Psychological. My signature indicates that I give my consent for my child to receive such services. I understand that I can contact Associates of Springfield Psychological to discuss how I may become involved in these services, as well as to learn more about the specific nature of the services to be provided.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

_____

Name of Child