Primrose Healing and Wellness
405 Primrose Rd.
Burlingame, CA 94010
650-558-1015

Consent to Treat Minor

I, _____, as the legal parent or guardian of _____, am responsible for authorizing medical treatment for the above-named minor. I have been fully informed about the therapy they will receive and understand both the potential benefits and risks associated with it.

I acknowledge that confidentiality is vital to fostering a trusting therapeutic relationship and agree that information shared by the minor with their therapist will be kept confidential, except in cases where the minor is at risk of harm to themselves or others. I also understand the legal limits to confidentiality regarding situations such as child abuse, neglect, or imminent harm.

I hereby give my consent for _____ to receive treatment from Primrose Healing and Wellness.

Signature: _____

Date: _____