

**Kristin Mills, M.A.**  
Licensed Marriage and Family Therapist  
License # MFC36444  
1815 Fourth Street, Santa Rosa, California 95404  
Phone/Fax: 707-527-6168

Consent to Treat a Minor

I, \_\_\_\_\_  
Parent(s)/Legal Guardian(s)

give permission to Kristin Mills, M.A., MFT (therapist) to provide psychotherapy for my  
child(ren) listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/legal guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/legal guardian

This consent is effective for one year after the date of signing unless stipulated below:

Effective date: \_\_\_\_\_ End date: \_\_\_\_\_