

Tara Schroeter, M.A., LMFT

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CONSENT TO EVALUATE AND TREAT MINORS

As parent or legal guardian of _____,
I authorize Tara Schroeter, M.A., LMFT to evaluate and treat the above named minor.
As parent and/or legal guardian, I have the right to request information regarding the
above minor's evaluation and treatment.

Parent Name _____

Parent Signature _____

Date _____