Kathleen B. Corcoran, Ph.D., Inc.

6611 Rockside Road, Suite 215
Independence, Ohio 44131-2344
216.462.0532 fax:216.524.7773

I consent that _____ may receive mental health services.

I also affirm that I am the parent or legal guardian and I am authorized to provide such consent. Mental health services may include individual, family, or group psychotherapy.

_____ _____

Print Name of First Parent or Legal Guardian Date

_____ _____

Signature of First Parent or Legal Guardian Date

_____ _____

Print Name of Second Parent or Legal Guardian Date

_____ _____

Signature of Second Parent or Legal Guardian Date

_____ _____

Witness Date