Dianne Voss Atteberry, MS, LCMFT
405 S Clairborne, Suite 1
Olathe, KS 66062

MINOR CONSENT

Date _____

This is to certify that I/we, _____, have legal custody or guardianship of the following child or children:

Name	Date of Birth

I/We give consent for him/her/them to receive individual and/or family therapy from **Dianne Voss Atteberry, MS, LCMFT**

_____

Legal Custodial Parent/Guardian Signature Date

_____

Legal Custodial Parent/Guardian Signature Date