Joseph J. Novak, Psy.D.
Clinical Psychologist
415 East Golf Road
Suite 115
Arlington Heights, Illinois 60005
847.308.4750

Parent/Guardian Consent for Treatment of a Minor

I hereby give consent for _____ to receive outpatient
Name of Minor

psychological services with Joseph J. Novak, Psy.D. This consent is valid for the duration of treatment. I have the right however, to revoke this consent at any time.

Signature _____ Date _____

_____
Relationship to Minor

Witness _____ Date _____