

**SUE GENARO LEGACY, ACSW, LCSW**

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**Psychotherapist  
4408 Spicewood Springs Rd. STE. 104  
Austin, Texas 78759**

**(512) 372-9595**

**CONSENT FOR TREATMENT**

**Adult (Age 18 Years & Up)**

I give full consent for completion of an evaluation and the provisions of ongoing mental health treatment as necessary until I otherwise notify this clinician.

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Signature

Date

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**Children and Adolescents (Age 17 Years and Under)**

I certify that as Parent/Guardian of \_\_\_\_\_,

I have the legal right to initiate mental health treatment on their behalf. I give my full consent for the completion of an evaluation and provision of treatment as necessary until I otherwise notify the clinician.

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Signature

Date