

**THERAPY CENTER
BOSTON GRADUATE SCHOOL OF PSYCHOANALYSIS
1581 BEACON STREET
BROOKLINE, MA 02446
TEL. (617) 277-3915**

Consent for Treatment of a Minor

I, _____ , hereby give my permission for my son/daughter, _____, to be treated in the Therapy Center at the Boston Graduate School of Psychoanalysis.

Signature of Parent or Guardian

Date