Living Hope
Eating Disorder Treatment Center

CONSENT FOR FAMILY THERAPY

I, _____ give permission to the following family member/partner(s) to attend family therapy services at Living Hope Eating Disorder Treatment Center.

Name: _____

Relationship to patient: _____

Phone Number: _____

Name: _____

Relationship to patient: _____

Phone Number: _____

Name: _____

Relationship to patient: _____

Phone Number: _____

Name: _____

Relationship to patient: _____

Phone Number: _____

_____

Signature of Patient Date