

CONSENT TO TREAT A MINOR

I _____ (*name of parent or guardian*), give my permission

to _____ (*name of counselor*) to see my son or daughter

_____ (*name of minor child*) for treatment or counseling with or without my being present during sessions.

I/we understand that we have the right to control the disclosure of private counseling information about my/our child.

Counselees under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child’s treatment records. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, I will provide them only with general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child’s treatment when it is complete. Any other communication will require the child’s authorization, unless I think the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Your signature on this document indicates your agreement/consent to give up your access to your child’s records.

Print Name _____

Parent’s signature _____

Print Name _____

Parent’s signature _____

Minor’s signature _____

Witness _____

Date _____