

## Consent for Counseling of Minors

Case Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Counselor(s) \_\_\_\_\_

This is to certify that I give permission

to \_\_\_\_\_ (name of therapist) to counsel my child listed above. I understand that the counsel received will be from a Biblical perspective and may include individual or group sessions. This treatment may include consultations with another therapist.

I understand that information disclosed in a session will be kept confidential, except where the law requires otherwise (child abuse, elderly abuse, physical danger to self or others, mental illness). This counseling (treatment) may also include referrals to other appropriate State and County professional agencies for further counseling. Pertinent information disclosed by the child will be shared with parents/guardians at the counselor's discretion.

There are no child custody court hearings pending. \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_ Printed Name of Parent/Guardian

\_\_\_\_\_ Street Address (City, State, Zip)

\_\_\_\_\_ Phone (Work/Cell)

\_\_\_\_\_ Phone (Home)