Name of Minor (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize and consent and agree for the above-named minor child to receive individual counseling from Therapist, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that as parent or legal guardian of the minor child named above, I am entitled to the information discussed in the counseling sessions. I also understand that asking for that information may affect the therapeutic relationship between the client and counselor.

I understand that I have the right to revoke this authorization in writing at any time with the exception to the extent that action already has been taken based on this authorization.

**NOTICE: If parents of minor child are divorced, we may require the signature of both parents prior to treatment if parents’ divorce decree stipulates such authorization is necessary for care of the minor child. By signing this agreement, I certify that I am authorized to sign on behalf of the minor child for treatment.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date