Healing Connections Inc.

CONSENT FOR TREATMENT OF A MINOR CHILD

Healing Connections is committed to assisting children and youth accessing counselling for therapeutic use. The information gathered during child/youth counselling sessions is confidential and ***is not to be used for court purposes***. Healing Connections has an ethical obligation of privacy to the children and youth we serve and recognizes the legal obligations to parents and guardians to keep their child(ren) safe.

(1) Name of the Child/Youth:____
DOB:________________________________ Age:__________

(2) Name of the Child/Youth:____
DOB:________________________________ Age:__________

(3) Name of the Child/Youth:____
DOB:________________________________ Age:__________

Regarding the Child(ren)/Youth named above, I am the:

☐Parent ☐Legal Guardian

- I am legally responsible for the child(ren)/youth named above and grant permission to Healing Connections to conduct therapy with them.
- I agree that these services are for therapeutic purposes only and the information gathered during the child(ren)/youth's involvement will not be used for court purposes.
- I understand that the counsellor has a duty to maintain confidentiality except when there is a danger to the client or others; where the abuse of a child has not been reported; or as required by law.
- In case of a minor, special sensitivity may be required in releasing information to the parent/guardian due to the therapeutic relationship with client and counsellor.
- I will accept the counsellor's professional judgment in regard to releasing or sharing information obtained during the course of counselling with the minor.

This consent expires if services are not accessed within 3 months or if services are discontinued for a period of 3 months.

Parent / Guardian Signature____
Print Name____
Parent / Guardian Signature ***(If two signatures are required)***____________________________
Print Name____

Witness____________________________ **DATE**________________________