AUTHORIZATION TO COUNSEL MINOR CHILDREN

I/We, ____ give my (our)
(Name of Parent (s) or Guardian)

consent to ____ to see my (our)
(Counselor)

son/daughter ____ for counseling
(Name of Minor Child(ren)

with and/or without me being present in the same session. I/We understand that we are the holder of confidential privilege – the right to withhold disclosure or private co8unseling information about my child. However, in the interest of developing a trust relationship between the counselor and my/our child(ren), I/we give the counselor permission to reveal or withhold information in his/her clinical judgment if necessary to best protect my (our) child(ren).

The only exception to this discretion would be in the case of:

____

____

____

I/We have legal custody of the child and have authorization to provide counseling for the child mentioned above.

The other birth parent is aware of this counseling _____yes _____no

Parent/Guardian Signature____
Date_______________
Parent/Guardian Signature____
Date_______________
Parent/Guardian Signature____
Date_______________

Counselor/Witness____
Date_______________