CONSENT FOR TREATMENT OF MINORS

To be completed by parent or guardian

Client/Child's Name____Date of Birth ________________________

I do respect the rights of parents. Confidentiality cannot be given without the permission of parents. The reality is that a child will have no reason to talk to a counselor if the counselor were to disclose all communications to a parent. Due to this problem, we ask you to permit your child to have a confidential relationship with their counselor.

This is to certify that I give permission to Peggy Rubio, LMHC (Positive Growth Counseling, LLC) to treat my minor child. This document permits my child to have a confidential relationship with a counselor. I understand that the information that my child discloses is private. Exceptions to this privacy include:

1. I sign a written release of information, therefore, waiving my and my child's right to privacy and providing Positive Growth Counseling permission to disclose information to the person or institution that I specify.

2. My child's counselor receives a court order to release information and will notify me that the requested information will be released.

3. My counselor feels that my child poses as a danger to self or others. This may include but is not limited to: high risk of suicide, perpetrator of abuse or neglect of a child or elderly person, homicidal plans.

4. My child is under 16 and my counselor feels that he/she currently/recently is victim of rape, incest, abuse or some other crime.

Signature of Parent/Guardian or Client__________________________________Date______________________

Printed Name of Parent/Guardian ____

Phone Number____Okay to leave messages? ☐ Yes ☐ No