CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian ____

Name of Minor ____

Minor's Date of Birth _________________________

Name of Counselor____

License Type: LPC Temporary Provisional Psychologist Psychologist

License # ____________

This is to certify that I give permission to HopeWorks Counseling Center for treatment of my child.

This counseling may include individual or family psychotherapy, counseling, and testing. This counseling may include consultations with other associates of this institution.

This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian__________________________ Date____________

Street Address ____

City/State/Zip ____

Home Phone ______________________Work Phone _____________________

Emergency Contact (Other than yourself):

Name _________________________ Phone _____________________

Witness/Title/Date ____