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CONSENT FOR TREATMENT OF MINORS

Including Parental "Allowance of Confidentiality"
Between a Minor Client and Therapist

Name of Minor Client: ______________________________

Date of Birth: ______________________________

Therapist/Counselor: ______________________________

Please verify that you are the custodial parent/legal guardian of this child and that you give permission to the therapist listed above to treat your child und the following conditions. Please also affirm that as custodial parent/legal guardian you do have the legal right to consent to counseling services.

In the state of Colorado there are legal exemptions to confidentiality.
These include situations where: (1) the client is imminently dangerous to themselves (suicidal struggles, grave disability) (2) the client is imminently dangerous to others (homicidal or serious physical violence) (3) there is a legal requirement to report child or elder abuse (4) you provide written authorization to release information (4) clients receiving treatment are minors (under the age of 18 at the time of treatment).

Regarding counseling with adolescents and clients under the age of 18:
My policy is to work only with minors where you as a parent/legal guardian agree to waive your right to communicate with me, and to have me communicate with you, regarding the explicit content of your child's counseling sessions, unless there is an "need to know" based upon danger to self or danger to others.

______________________________ ____________
Signature of Custodial Parent/Legal Guardian Date

______________________________ ____________
Signature of Custodial Parent/Legal Guardian Date