Oak Creek Relational Counseling Center

CONSENT TO TREAT A MINOR

I, (We), _____ as the parent(s)/legal guardian who has/have sole/joint custody of _____ hereby grant permission to Oak Creek Relational Counseling Center and _____Marriage and Family Therapist/Professional Clinical Counselor/Associate/Trainee, to provide psychotherapy for my (our) child in the form of individual, conjoint or group sessions. I (We) understand that these sessions will be private, but the therapist will inform me (us) about the child's general progress and promises to involve me (us) immediately if needed to avert danger to my (our) child.

You have a right to request and receive a copy of this Authorization for Release of Information.

Date: _____

Parent's Signature: _____Parent's Signature: _____

MFT/PCC/Associate/Trainee: _____

***If joint legal custody*:** I understand that as a parent with joint legal custody it is my responsibility to inform the other legal custodian that _____ is participating in counseling at Oak Creek Relational Counseling Center. I understand that the other legal custodian may seek information and/or records pertaining to this counseling and /or may object to counseling for the minor(s) and terminate treatment.

Parent/guardian signature: _____

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