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 _____