

NEW SOURCE COUNSELING CENTERS

Authorization to Treat Minor Children

I, _____ (parent/guardian) give permission to:

_____ (counselor) to see

_____ (son/daughter) for

counseling and/or treatment, with or without my being present in the same session. I understand that the counselor is the holder of confidential privilege, which is the right to withhold disclosure of private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my child, I give the counselor permission to reveal or withhold information that in his/her clinical judgement is necessary to best help and protect my child. The only exception to this discretion would be in the case of potential threat to the child's safety, the safety of others, or in the case of:

I also verify that I am the legal and custodial parent or guardian of this child.

Parent/Guardian signature: _____ **Date:** _____

_____ **Date:** _____

Counselor/Witness: _____ **Date:** _____