CONSENT FOR COUNSELING MINORS

Minor's Name ____

Date of Birth ___________________________ Age ______________________________

This is to certify that I give permission to Safe Harbor Counseling Center for the treatment of my child. I understand a copy of current court orders must be provided before child can be seen.

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

This counseling may also include referrals to other appropriate State and County or professional agencies for further counseling.

____ ___________________
Signature of Parent/Guardian Date

____
Printed Name of Parent/Guardian

____
Street Address

____
City/State/Zip

____
Phone Number

____ ___________________
Witness Signature Date

____
Printed Name of Witness