sacred ground. counseling

Authorization to Counsel Minor Children (15 years and younger)

I, _____ give my permission to
(Name of Parent (s) or Guardian)

_____ to see my son/daughter,
(Counselor)

_____ for counseling with and/or without
(Name of Minor Child)

me being present in the same session. I understand that I am the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trusting relationship between the counselor and my child, I give the counselor permission to reveal or withhold information which, in his/her clinical judgment, is necessary to protect the therapeutic experience and clinical gains for my minor child. The only exception to this discretion would be in the case of

_____
_____
_____.

I have legal custody of the child and have authorization to provide counseling for the child named above.
The child's other birth parent _____ is _____ is not aware of this counseling.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date