Krupnick Counseling Associates

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PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Child's Name: _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, treatment and/or psychological assessment from the professional staff associated with or employed by Krupnick Counseling Associates. If applicable, I have provided a copy of the most recent Court Order Custody Agreement and/or Parenting Plan that gives me the authority to consent to the treatment of the minor child. By signing this form, I agree to keep Krupnick Counseling Associates informed of any supplemental court orders or other proceedings that impact my parental rights, custody arrangements, or decision-making authority. If there is joint medical decision-making authority for the minor child, both parents or guardians must consent to treatment and services will not proceed unless such consent is obtained.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

_____ _____

Signature of Parent, Guardian or other person authorized by law to consent | Date

_____

Mailing address

_____ _____ _____

Home Phone | Work Phone | Cell Phone

_____

Email Address