HOPE IN HOME COUNSELING, LLC

727-612-3343/ kathleen@hopeinhomecounseling.com

Consent for Treatment

I,_____parent/guardian of _____
(Name of Parent/Guardian) (Name of Child)

agree to treatment of counseling with Kathleen Rodriquez, LCSW of HOPE In Home Counseling, LLC.

Signature_____ Today's Date_____
(Signature of Parent/Guardian)

HOPE In Home Counseling, LLC

Release of Information

I_____BD_____consent the release of information regarding my therapy to _____.

This document is good for one year, but I may rescind it at any time, in writing.

Print Name_____ Date_____

Signature_____