Consent for Treatment of a Minor

I, _____, (parent/guardian name) attest that I am the Legal Custodial Parent (or) Legal Guardian of _____, (name of the child/adolescent client) and I give Veritas and Shannon Lowell permission to provide treatment for my child/adolescent.

Confidentiality Statement

We understand the limits to confidentiality and have been provided with a copy of this statement.

For the Parent/Guardian: The right of confidentiality is maintained with three exceptions:

1. The professional has reason to believe you will harm yourself. 2. The professional has reason to believe that you will harm others, including the minor. 3. The professional has reason to believe that someone or something is harming your minor child, including the parent(s) or guardian(s).

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe you will harm yourself. 2. The professional has reason to believe you will harm others. 3. The professional has reason to believe that someone or something is harming you, including the parent(s) or guardian(s).

Additional Disclosures at Request of Parent or Guardian:

My signature below attests to the fact that I am the legal custodial parent/legal guardian of the minor to receive treatment.

Parent/Guardian Signature:

_____

Date:

_____

Minor Signature:

_____

Therapist Signature:

_____

Date:

_____