



Fairbanks Therapy Associates, Inc.

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Consent to Treat a Minor

I, give my permission to _____ to **(Parent/Guardian)**

(Counselor) see my child for counseling or assessment. _____ **(name of minor child)** can be seen with or without my presence during sessions **(initial_____)**.

I understand that I have the right to control the disclosure of private counseling information about my child. However, in the interest of resolving the issues we have brought to the counselor, I give the counselor permission to reveal to or withhold from me or others information that, in the counselor's judgment, is necessary to best help and protect my child **(initial_____)**.

Beyond my signing an *Authorization for Release of Protected Health Information*, the only exception to this would be in the case of:

(Parent/guardian should write "not applicable" in the previous space if appropriate)

My signature below asserts and confirms my legal authority to sign on behalf of the minor

Parent/Guardian _____ Date _____

Counselor _____ Date _____