S·U·N·S·T·O·N·E
COUNSELING

INFORMED CONSENT FOR TREATMENT OF A MINOR

Minor's Name: _____ Date of Birth: ____/____/____

Minor's Primary Address: _____
_____

Is there a custody agreement with another parent/guardian? Yes No

If yes, please describe the agreement. (If custody is shared, please indicate if your agreement requires permission from both parents/guardians for the minor to receive counseling services: _____
_____
_____
_____

By signing to authorize services for a minor, you are stating that you have the legal right to authorize such services for the minor and that no further consent by a parent or legal guardian is required by any law, court order, or otherwise. Any person under the age of 18 years of age is considered a minor.

I (Print name) _____, am the mother/father/legal guardian (circle one) of _____, and I authorize and consent to mental health services to be rendered by Sunstone Counseling.

_____ _____
Parent/Guardian Signature Date