Serenity Family Services

PERMISSION to COUSNSEL MINOR CLIENTS
(AGES 6-18 YEARS OF AGE)

Name of Client_____

Date of Birth_____

Social Security Number of Insured_____

I, hereby, authorize_____ to counsel my minor child. I, _____as the custodial parent/guardian grant permission for my child to be seen in individual, family, and/or group therapy as needed.

I, hereby, certify that I am the above- named client (or the legal guardian of that client.)

This consent may be revoked by me (in writing) at any time and will automatically expire 90 days of date signed.

PLEASE INITIAL: Client_____ (or) Legal Guardian_____

Signature_____

Address_____

_____

_____

Witness_____

Today's Date_____