CANTERBURY COUNSELING CENTER

CONSENT FOR TREATMENT OF MINORS

Client name _____

Date of Birth _____

Counselor(s) _____

This document certifies that I give my permission to CANTERBURY COUNSELING CENTER and the counselor listed above for treatment of my child. This treatment may include individual or group psychotherapy, counseling and testing. This treatment may include consultation with other associates of this institution. This treatment may also include referrals to other appropriate state and county or professional agencies for further counseling.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

_____

Street Address

_____

City/State/Zip

_____

Phone

_____

Witness / Title

Click Here To Print This Form And Take It With You To The Office

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