Loretta Parker, LMFT
Reconnection Family Counseling Services
Consent for Treatment of Minors

Name of Minor:_____

Date of Birth:_____

This is to certify that I give permission to Loretta Parker,LMFT, for treatment of my child/guardian. This treatment may include individual, family, or group psychotherapy, counseling and testing. This treatment may include consultations with other associates including Educational Psychologists, Psychiatrist, Career Counselors or Nutritionists. California State law mandates the reporting of certain types of childhood abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate state and county agencies for further counseling. It is also a mandatory reporting issue if the child is found to be a harm to self or an identifiable other person/people. All material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

My relationship to the client (parent, uncle, grandparent, etc.)

_____

I was notified that the holder of the privilege is (parent, guardian, etc.)

_____

_____ _____

Signature of Parent/Guardian Date

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