Name of Person Giving Consent: ____

Your Relationship to Minor (check one):

☐ Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian ☐ Other ______________________

Name of Minor: ____ Date of Birth: ______________________

This is to certify that I give permission to <u>Counseling by Penny Haight M.Ed., LPC-S, PLLC</u> for treatment of my minor child.

This counseling may include individual or family psychotherapy, education, and assessment.

I consent to the following psychotherapy services for the minor named above (check & initial <u>all that apply</u>):

☐ ________ Initial Clinical Interview / Evaluation

☐ ________ Individual/Family Therapy

☐ ________ Group Therapy

☐ ________ Biofeedback

☐ ________ Academic Tutoring

As a parent/legal guardian, I understand that I have the right to information concerning my minor child in therapy except where otherwise stated by law. I also understand that Counseling By Penny Haight believes that providing a minor child a safe and private environment in which to disclose his or her feelings and emotions can facilitate therapy. Therefore, I give permission to Counseling By Penny Haight to use their discretion in accordance with professional ethics and state law in deciding what information revealed by my child is to be shared with me.

X ____ ____________________________________

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Parent/Guardian Signature *Date*