

GENEE FRANCIS, LPC-S, NCC

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PERMISSION FOR TREATMENT OF A MINOR CHILD

Minor's Legal Name _____ Date of Birth ____/____/____ Age ____

I, _____, am the legal custodian of the above-named minor.

Please check one.

- I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
- I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person. (In this case, the signatures of both parties sharing Joint Conservatorship are required below)

CONFIDENTIALITY AND THE TREATMENT OF MINORS

The parents or legal guardians of clients under the age of 18 have the right to access their child's psychological records. The exception to this is in the case of an emancipated minor. Your child's therapist will discuss with you the limitations, procedures, and implications regarding your child's records and progress.

_____ I hereby authorize Genee Francis, LPC-S, to provide counseling to the minor stated above about behavioral challenges, substance abuse, mental health, and / or other personal problems.

_____ I further affirm that I have the legal authority to seek and grant permission for psychological treatment for the above-mentioned minor child. There being no legal decree or modification to my knowledge disallowing my authority to assume such responsibility.

_____ In cases of separation or divorce: I have provided legal documentation (divorce decree or current court orders) regarding conservatorship/guardianship and my legal right to consent to treatment for my child.

Printed Name of Parent/Guardian 1

Date

Signature of Parent/Guardian

Relationship to the client

Printed Name of Parent/Guardian 2 (IF APPLICABLE)

Date

Signature of Parent/Guardian 2 (IF APPLICABLE)

Relationship to the client

(FOR OFFICE USE ONLY)

RECEIVED COPY OF LEGAL CUSTODY DOCUMENTS ON: _____ BY: _____