CONSENT TO PROVIDE SERVICE TO A MINOR

(A minor is any client age 17 years old and under)

Client ____

Client ID # ____________________________ Date of Birth _____________

"I, ____, ________________
Print Name of Responsible Party Relationship to Minor

Hereby authorize PREVAIL COUNSELING GROUP, PLLC to provide treatment to the above name client – minor.

As a parent, I understand that I have the right to information concerning my minor child in therapy, except where otherwise stated. I also understand that this therapist believes in providing a minor child with private environment in which to disclose him/her to facilitate therapy. I therefore give permission to this therapist to use his/her discretion, in accordance with the professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

____ _____________
Signature of Responsible Party Date

____ _____________
Witness Date