SOUTHERN CALIFORNIA COUNSELING CENTER

CONSENT FOR TREATMENT OF MINOR – SCHOOL-BASED PROGRAM

I/We, _____ give my/our consent to
(name of parent, guardian or caregiver)

Southern California Counseling Center to conduct counseling/psychotherapy with the minor client,

_____.
(name of minor client)

My/our relationship to the minor client is _____.

I/we were notified that the holder of the psychotherapist-patient privilege is

_____.
(name of minor client)

I/we were also notified that all material discussed during the counseling/psychotherapy sessions is generally confidential unless disclosure of such information is demanded or permitted by law, as explained in the Client Information Sheet that I/we have read and signed.

I/we were also notified that the minor client may have the right to authorize the release of confidential information, especially if the minor client did or could have consented to counseling/psychotherapy her/himself.

I/we were also notified that the counselor has the right to withhold confidential information from me/us if 1) the minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the counselor's professional relationship with the minor client, or 2) the minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the minor client's psychological safety or well-being.

I/we understand that Southern California Counseling Center will exercise clinical judgment in disclosing any information derived in the confidential relationship with the minor client that indicates that the well being of the minor may be in danger or jeopardy. I will accept Southern California Counseling Center's judgment in releasing and sharing such information obtained during the course of counseling/psychotherapy.

Name	Relationship	Signature	Date

Name	Relationship	Signature	Date

If the person(s) signing this consent is/are either (1) the parent of the child and legally separated or divorced from the child's other parent, or (2) not the parent(s) of the child, please attach a copy of the document, or portion thereof, which authorizes you to make healthcare decisions for the child.

_____
Alyssa Mass, MFT
Training Director, School Based Program
Southern California Counseling Center

_____	_____	_____
Counselor Name Southern California Counseling Center	Counselor signature	Date