New Dawn Counseling Center
3370 Vineville Ave., Ste. 110
Macon, GA. 31204
PH: (478) 254-3751
Fax: (478) 254-3752

Consent for Treatment of Minor Child

I agree to therapeutic services provided to my minor child at this office.

Client/Child's Name____
Client/Child's Address____
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As a parent/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 this therapist believes in providing a minor child with a private environment in which to disclose himself / herself to facilitate therapy. I therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with me.

Custodial Parent/Guardian:

____
Printed name

____
Address (if different from above)

If guardian, relationship to the child: _______________________________

____
Signature

____
Date