CONFIDENTIAL

Counseling Services Permission Form

Student Name_____________________________ Teacher______________________ Grade___________

Parent/Guardian Name________________________ Parent/Guardian Phone Number _____________

○ Yes, I give permission for my child to receive counseling services.

○ No, I choose not to use this service at this time.

CONFIDENTIALITY

For therapy to be effective, confidentiality must be honored. Additionally, information your child shares with the counselor in his/her private sessions will be held confidential. However, the goals and progress of the counseling may be shared with you or any other legal custodial parent or guardian. No information will be shared with anyone outside of the counselor's office without your written consent.

By law, confidentiality must be breached in the following areas:

- if a therapist suspects that any minor, elder or dependent adult is being or has been abused
- if a person plans to harm him/herself
- if a person plans to physically harm another person
- if your file is subpoenaed to court

Please include any helpful information about your child below:

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○ Yes, I understand all the information stated in this form.

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Parent/Legal Guardian Signature Date