JEWEL ANDERSON
Licensed Professional Counselor

CONSENT FOR TREATMENT OF MINOR AND AUTHORIZATION FOR CONFIDENTIALITY

This is to certify that I/We, , have legal custody or guardianship of the following child(ren):

Child's Name Date of Birth / /

Child's Name Date of Birth / /

Child's Name Date of Birth / /

Child's Name Date of Birth / /

Child's Name Date of Birth / /

And give consent for him / her / them to receive individual and/or family therapy from Jewel Anderson, LPC NCC

I further consent, in the interest of maximizing the effectiveness of the services provided, that the content of this therapy, with the exception of the content of any given session where I may be invited to be present, will be considered confidential and will not be divulged to me unless otherwise agreed by my child(ren).

Legal Custodial Parent/Guardian Signature Date

Legal Custodial Parent/Guardian Signature Date