Consent for Treatment of Vulnerable Adult or Minor

Name:_____________DOB:____________SS#_________________________________

I, ________________ , am certifying that I am the Parent or Legal Guardian of

____________________(Your Story Matters Counseling Client) and give my permission for this client to receive mental health/day treatment services at Your Story Matters Counseling.

Your Story Matters Counseling utilizes group therapy, individual therapy and family therapy sessions, as needed. The services provided to this client may include any variation of these types of therapy. Participation requirements, team recommendations and treatment team considerations are the medium by which decisions are made regarding what is appropriate for each client.

I understand that I am not legally required to consent to mental health and day treatment services. If I do not provide consent, however, it may interfere with or prevent the person served from admission and/or treatment at Your Story Matters Counseling.

I understand that the information released is private and cannot be released without my consent, unless allowed by law/statutes.

I understand that this consent will not be used for any other purpose, except for the purpose communicated to me for which I have authorized, unless authorized by law/statutes. Access will be limited to the qualified staff of Your Story Matters Counseling to perform the purposes outlined above.

I understand that I may petition for the revocation of this consent at any time in writing. This consent will expire one year after I sign this document, unless I renew the consent one year after initial signature. Renewals will be initialized and re-dated.

Signed____________________Date ________ Signed____________________Date________
(CLIENT SIGNATURE) (PARENT or GUARDIAN SIGNATURE)