

TrueNorth Christian Counseling

50200 W Ten Mile Rd. Novi MI 48374

248- 374-6003

CONSENT FOR TREATMENT FOR MINOR/S

I _____

Give my consent to TrueNorth Christian Counseling to conduct counseling/psychotherapy

With _____

My relationship to the client (parent, uncle, etc.)

I was notified that the holder of the privilege is (parent, guardian, etc.)

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Informed Consent form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs or sex. I will accept the TrueNorth therapist judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's well being.

Name (print)	Relationship	Signature	Date
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Therapist