211 S. Primrose Ave.
Monrovia CA 91016
(626)359-4330

Minor Consent for Treatment

This confirms that ______________________________________ is a minor consenting to his/her own treatment *without written consent from a parent/guardian*.

Your therapist will respect your privacy and keep your treatment and information shared in session as confidential. However, if your therapist feels there is an issue that may relate to your safety, they may need to discuss that issue with your parent/guardian.

This is in addition to and potentially outside of the issues already listed in the general ***Consent for Services*** *form and they will always alert you to this, if it applies*.

There are also times when it is helpful to involve parents/guardians in various ways. This may include things like updates or discussion before or after our session, joint sessions where we all meet together, or phone calls. We will all discuss this together if any of these seem beneficial over time.

As noted in the section of the Consent for Services, *Medical Records and Your Right to Review Them*, your therapist keeps notes about your sessions together. In some circumstances, you have the right to determine whether or not your parents/guardians may view these records. If there is a request to release or view any of your records your therapist will discuss this further with yourself and, if applicable, your parent/guardian to determine the appropriate action.

Please note that your therapist will document what circumstances allow you to consent to your own treatment as a minor.

____

Client Signature **Date**

____

Therapist Signature **Date**