Aurora Family Counseling Center

Consent for Treatment of Minors

Client's Name: ____

DOB: ____________ Therapist Name: ___________________________

This is to certify that I have given permission to the therapist named above for treatment of my child. This treatment may include individual, family or group psychotherapy. Psychological testing and assessment may also be a necessary part of treatment.

On occasion your therapist may consult with other professionals regarding your child. Consultation may be with teachers, educational psychologists, guidance counselors, physicians or psychiatrists.

California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will need to be reported to the appropriate agency. In such an instance you may be referred to other State and County agencies for further counseling.

☐ Sole Legal Custody
☐ Joint Legal Custody
☐ Other: _________________

FOR OFFICE USE ONLY
☐ Documentation of Sole Legal Custody Agreement obtained and copy of agreement on file.
☐ Consent received from all responsible parties.

______________________________ ________________
Signature of Parent /Guardian Date

____
Printed Name of Parent /Guardian

____
Address

______________________________ ________________
Signature of Parent /Guardian Date

____
Printed Name of Parent /Guardian

____
Address

24977 Washington Avenue, Murrieta, CA 92562
Phone 951.677.1470 Fax 951.677.3850