DAEHNERT COUNSELING
Restoring Lives, Embracing Freedom

CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian _____

Name of Minor _____

Minor's Date of Birth _____

Name of Counselor_____

License Type: **X** LPC

License # **18194**

This is to certify that I give permission to **Daehnert Counseling LLP** for treatment of my child. This counseling may include individual or family psychotherapy, counseling, and testing. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

I hereby waive my right as a parent to obtain information from and copies of any records from Todd Daehnert, M.A., LPC and **Daehnert Counseling LLP** pertaining to the evaluation and treatment of the following child: _____, age ____. I understand that Daehnert Counseling LLP *may* refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's therapist would negatively impact the child or the child's evaluation and treatment. I hereby release Todd Daehnert, M.A., LPC and **Daehnert Counseling LLP** from any and all liability for good-faith refusal to disclose the child's information or records.

Signature of Parent/Guardian_____ Date_____

Street Address _____

City/State/Zip _____

Home Phone _____Work Phone _____

Emergency Contact (Other than yourself):
Name _____ Phone _____

Witness/Title/Date _____