



**Student Health & Counseling**

**Parental / Guardian Consent for Treatment**

**(Parent/guardian must sign below for authorization for students under 18 years old)**

I/we understand that in order to render effective treatment, strict confidentiality must be maintained between the professional mental health counselor and the client (student). To support this environment of trust between the counselor and client, I/we (parent/guardian) consent to a *limited* release of information regarding my/our child between the counselor and me/us.

I/we hereby authorize you to enter into a professional counseling relationship with:

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Student’s Name

This consent is effective through the current academic year including the subsequent summer semester.

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Parent / Guardian Signature Date

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Printed Name Parent/Guardian Phone Number