Jessica Davidson

Licensed Professional Counselor | Child & Adolescent Therapy

Authorization To Counsel Minor Children (15 years old and younger)

I _____ give my permission to
(Name of Parent (s) or Guardian)
Jessica Davidson, LPC-MHSP to see my son/daughter,
(Therapist)

_____ for counseling with and/or without
(Name of Minor Child)

me being present in the same session. I understand that I am the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trusting relationship between the counselor and my child, I give the counselor permission to reveal or withhold information which, in his/her clinical judgment, is necessary to protect the therapeutic experience and clinical gains for my minor child. The only exception to this discretion would be in the case of

_____.

I have legal custody of the child and have authorization to provide counseling for the child named above.

The child's other birth parent _____ is _____ is not aware of this counseling.

_____ (initial). I have agreed to provide a copy of my parenting plan that outlines my agreement in shared parenting so that the counselor may work in the best interest of the family.

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Therapist Signature) (Date)