Treatment Consent and Authorization

Minor Child

I, _____, authorize Joan Forest LICSW to assess, diagnose, create a

treatment plan and carry out treatment for minor child_____.

By signing below, I assert that I have the right to make medical decisions for the child. If there is a divorce

decree, please provide a copy of the most recent parenting plan to therapist. If medical decisions for the

child are shared between two divorced parents, each must sign to agree to treatment.

Joan Forest LICSW keeps a record of treatment which is confidential except for the following situations:

-Communication with billing agencies and insurance companies for the purpose of reimbursement.

- If child or vulnerable adult abuse is revealed.

- If grave bodily harm or death is threatened to the self or others.

-If a court of law issues a legitimate subpoena.

Other than these circumstances, no information will be revealed without Joan Forest LICSW obtaining a signed release from the client or from the minor child's parent or guardian if child is under 13 years of age.

Signature_____Date_____

Print name_____