Consent to Treat Minor

I, _____ custodial parent/legal

guardian of _____, age _____,

authorize Kelley Armbruster, LISW, DAPA, to assess and treat my child in this outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parental unit.

Parent #1/Guardian's
Signature _____ Date _____

Relationship _____

Parent #2/Guardian's
Signature _____ Date _____

Relationship _____

(I like to get both parents signature when it is possible).

Signature of Counselor _____Date _____

Children under 18 years of age under Ohio law generally have no right to confidentiality where their parent(s)/legal guardian(s) are involved, with the exception, that minors 14 years of age or older may receive certain limited outpatient services without the information being disclosed to the parent(s) or guardian(s) under most circumstances. Other than that specific exception, both parents/legal guardian(s) generally have a right to obtain all information on their minor children, unless specifically blocked from access by a court order.

*****Signature of Minor Child/Acknowledging he or she has read the above**

statement: _____Date_____