GOLDEN SKY
COUNSELING
Rikki Goldenberg, LMHC

PARENTAL CONSENT FOR THERAPY WITH A MINOR

Name of Child: _____ DOB: _____

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment.

Therapy is most effective when a trusting relationship exists between the therapist and a child. Privacy is especially important in securing and maintaining that trust. It is necessary for children to establish a "zone of privacy" with their therapist that allows them to feel free to discuss personal matters. Therefore, it is my policy to provide you with general information about the treatment of your child, but I will not share with you what your child has disclosed to me without your child's consent. However, if I ever believe that your child has been abused or is at serious risk of harming him/herself or another, I will inform you. This "zone of privacy" extends to the information contained in treatment records as well. By signing this agreement, you are waiving your right to access to your child's treatment records. I will be happy to provide a written treatment summary upon request.

Adolescence is a time when children need to develop a greater sense of independence and autonomy. If your child is an adolescent, it is possible that he/she will reveal sensitive information during therapy sessions regarding sexual contact, alcohol and/or drug use, or other potentially problematic behaviors. In order for me to effectively work with your child, it is necessary for me to maintain confidentiality about these behaviors unless they involve imminent risk of harm to self or others, such as driving while under the influence of alcohol or drugs. I will also inform you if your child does not attend sessions or if it is necessary to refer your child to another mental health professional.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and a therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully and try to understand your perspectives, while fully explaining mine. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. If either parent decides that therapy should end, I ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

If conflicts arise between parents, you understand and agree that my role is strictly limited to providing psychotherapy for the benefit of your child. This means, among other things, that you will treat anything said in session as confidential and you will not attempt to gain an advantage in any legal proceeding from my involvement with your child. You agree that you will not involve me in any legal dispute, especially a dispute concerning custody or visitation arrangements. You will not ask me to testify in court, either in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Thank you for your understanding and cooperation. If you have any questions about the information contained in this document, please discuss them with me prior to signing below.

PARENTAL AGREEMENT TO RESPECT PRIVACY

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in a confidential consultation with her consultant/supervisor.

Parent/Guardian:

Signing below indicates that I have reviewed the policies described above and understand the limits to confidentiality and agree to respect my child/adolescent's privacy.

_____	_____
Parent/Guardian Name	Parent/ Guardian Name
_____	_____
Parent/ Guardian Signature	Date
_____	_____
Parent/ Guardian Signature	Date
_____	_____
Therapist Signature	Date