WHITE OAK Counseling and Recovery
125 E Main Street, Middleville, MI 49333
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Counseling Minors

I/we, _____ (name of parent/guardian), give my/our permission to _____, therapist with White Oak Counseling and Recovery, to see my/our son or daughter _____ (name of minor child) for treatment or counseling with or without my being present during sessions.

I/we understand that I/we have the right to control the disclosure of private counseling information about my/our child. However, in the interest of resolving the issues I/we have brought to the therapist, I/we give the therapist permission to reveal or withhold information to/from us or others that in the therapist's judgment is necessary to best help and protect my/our children. The only exceptions to this discretion would be in the case of lethality and:

1) _____

2) _____

(Client should write "not applicable" in the previous space if appropriate.)

_____ Date: _____
Signature of Minor Child

_____ Date: _____
Name of Parent/Guardian

_____ Date: _____
Signature of Therapist