



# AUTHORIZATION TO TREAT A MINOR

*The State of Pennsylvania, for the purposes of mental health counseling, defines a minor as any child under the age of fourteen.*

[www.lifestrategyconsultants.com](http://www.lifestrategyconsultants.com)

Phone: (717) 376-3075

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Client Name [Minor] \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

When treating minors, Life Strategy Consultants, LLC makes every effort to obtain permission from both biological parents and/or guardians prior to beginning treatment. We believe that this united support is vital for effective treatment of minors. If permission cannot be obtained from both biological parents and/or guardians, treatment will proceed at the discretion of the clinician.

By signing below, parents/guardians understand and agree that they are privileged to confidential information regarding their child's treatment, but in order to engage in the most effective treatment they may or may not be present in the counseling room during treatment. Additionally, in the interest of developing a trust relationship between child and clinician, the parents/guardians give the clinician permission to reveal or withhold information that in their clinical judgment is necessary to best help and protect the child. The only exception to this discretion would be in the case of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to client \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to client \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please provide a COPY of any court orders that provide clarification of custody issues, medical rights, guardianship, or any other judgements related to the care and custody of this minor.**

