**Parental Consent for Treatment of a Minor**
**SUNY GENESEO COUNSELING SERVICES**

I hereby give consent for Counseling Services to provide individual counseling, group counseling, and/or psychiatric consultation to my minor child,

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(name of student)

I understand that:

- My minor child has the right to refuse diagnostic or treatment services.
- Any specific information which my minor child shares in counseling will be treated with the strictest confidentiality. I also understand that there are important legally mandated exceptions to confidentiality. These include:
  1 ) notification of relevant others when a clinician judges that a client is in immediate danger to self or others, as for example, in the case of suicide or homicide;
  2 ) the clinician must report any incidence of suspected child abuse, neglect, or maltreatment in order to protect the children involved; and
  3 ) in legal cases, clinicians or clinical records may be subpoenaed by a judge.

  Otherwise, I understand that confidential information will not be disclosed without my minor child's written authorization to do so.

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Your name (printed) Your relationship to student

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Your Signature Today's Date