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 son/daughter,

_____

(name of student)

I understand that:

- My son/daughter has the right to refuse diagnostic or treatment services.

- Any specific information which my son/daughter 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 elder or child abuse, neglect, or maltreatment in order to protect the elderly and/or 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 son/daughter's written authorization to do so.

_____ _____

Name (**printed**) Relationship to Student

_____ _____

Signature Date

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Health Services
Phone (585) 245-5736
Fax (585) 245-5744

Counseling Services
Phone (585) 245-5716
Fax (585) 245-5071

Health Promotion
Phone (585) 245-5747
Fax (585) 245-5744

Accredited by
Accreditation Association for Ambulatory Health Care, Inc.