PARENTAL CONSENT FOR TREATMENT OF A MINOR
SUNYGeneSEO 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