FAMILY COUNSELING CENTER
1347 GRANT ST.
RED BLUFF, CA 96080
PHONE : (530) 527-6702 **FAX:** (530) 527-6758

CONSENT FOR COUNSELING A MINOR CLIENT

Minor Client Name:____

1) Primary Parent/Guardian Name:____________________________
2) Secondary Parent/Guardian Name:__________________________

By signing this consent I/We have claimed to be the legal guardian(s) of the minor child listed above. Under Penalty of perjury, I/we claim to have the legal authority to authorize counseling for this child. **NOTE: claiming to have sole custody of a minor child without court declaration or claiming to be a legal guardian without actual legal authorization constitute fraud by misrepresentation.**

This signed consent authorizes FAMILY COUSELING CENTER OF TEHAMA COUNTY to provide private counseling to the minor child named above. This also authorizes summary treatment/diagnosis information about the minor child to be released to the parent(s)/guardian(s).

Consent hereby given on this date:_________________________________

Signature, 1) Parent/Guardian_____________________________________

Signature, 2) Parent/Guardian_____________________________________