Creative Counseling Center, LLC
6021 S. Syracuse Way Suite 216
Greenwood Village, CO 80111
303.843.6000

CONSENT FOR TREATMENT OF MINORS AND CUSTODIAL PARENT RELEASE OF CONFIDENTIAL INFORMATION FORM

Client Name ____

Date of Birth ____

Therapist(s) ____

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I verify that I am the custodial parent/legal guardian of this child/ren and I give permission to the Institute staff, students, interns, clinic, and the counselor(s) listed above for treatment of my child. I also affirm that as custodial parent / legal guardian I do have legal right to consent to treatment. This treatment may include individual, family, or group psychotherapy, counseling, and testing. This treatment may include consultations with other therapists as needed. I also give permission/release for my psychotherapist to contact anyone she or he needs to contact to gather data for assessment purposes and to facilitate the treatment of my child/children, me, and my/our family.

____ ______________
Signature of Custodial Parent/Legal Guardian Date

____ ______________
Printed Name of Custodial Parent / Legal Guardian Phone

____
Street Address

____
City/State/ZIP