Consent for Treatment of a Minor

I agree to therapeutic services provided to the minor named below by Margaret Stearns, MSW, LICSW.

Client's Name_____

Address_____

Parent(s)/Guardian(s) Signature_____

Address (if different than client's address)_____

I understand that I have the right to information concerning the above named minor in therapy, except where otherwise stated by law (Minnesota Stat 144.341-342) and in the following circumstances: when the minor is married, legally emancipated, has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy related conditions (Minnesota Statue 144.343).

I also understand that in order for this therapist to facilitate therapy, the client's privacy will be upheld. I therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws/rules, in deciding what information revealed by the client is to be shared with me (Minnesota Statue 144.355 subd 2).

Signature_____ Date _____
Parent/Guardian