Patty L. Yule, M.S., LPCC (Lic. #177)
Licensed Professional Clinical Counselor

CONSENT FOR TREATMENT OF A CHILD/ADOLESCENT UNDER 18 YEARS

Client Name: _____

I/We, _____, give permission and consent for Patty L. Yule, LPCC to see the above named child/adolescent for counseling with or without my/our presence during sessions. I certify that I am the Father, Mother, or Legal Guardian of this child/adolescent.

I/We give Patty L. Yule, LPCC permission to protect and maintain the confidentiality of the content shared during my/our child's therapy sessions. I/We understand that protecting my/our child's private communications with the therapist is necessary in order to create safety and trust between Patty L. Yule, LPCC and my/our child. The only exception to this would be if, in the therapist's professional judgment, information needed to be shared with me/us in order to prevent harm from coming to my/our child or someone else.

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____

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