Consent for Treatment of Minor

Pennock Center for Counseling
211 South 21st Avenue
Brighton, CO 80601

Child's Name: _____

Child's Date of Birth: _____

I/We_____

am/are the legal custodial parent(s) of _____

and give my/our permission to _____, to provide counseling
(name of therapist)
services to my/our child (children).

Pennock Center maintains electronic health records. Scanned images of signatures on all agency forms will be considered original, binding and legal.

Signature of Parent/Guardian **Date**

Signature of Parent/Guardian **Date**

Signature of Therapist/Witness **Date**