



CONSENT TO COUNSEL A MINOR

Date: _____

Name of Minor Client: _____

Name of Person Granting Consent: _____

Do you have full or joint legal custody of the minor? (Circle one) YES NO

Relation to minor: _____

Cell Phone: _____ Home Ph#: _____ Work Ph#: _____

Is it ok to leave a voice message? Y N

Email: _____

Mailing address: _____

Emergency Contact (Name and Phone number): _____

I, the undersigned responsible parent or legal guardian, hereby authorizes Gayle Long, MS, MA, LMFT of The Empowerment Center, to provide counseling to the minor whose name appears on this form.

Parent/Legal Guardian

Date

Parent/Legal Guardian

Date