CONSENT TO COUNSEL MINOR

I, _____ authorize
(Parent/Guardian)

_____(Clinician Name) at Hope and Wellness Center, P.C. to counsel with

_____
(Minor's Name)

At times, it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the most timely treatment for you and your children.

I understand that this consent to counsel may be revoked at any time and will automatically expire without my expressed revocation one year from the date signed.

_____ _____
Date Parent/Guardian

_____ _____
Date Witness