

SIERRA COUNSELING & MEDIATION, LLC

2900 Frank Scott Parkway West Suite 986 Belleville, IL 62223

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CONSENT TO TREAT A MINOR

I, _____ do hereby attest that I am the legal, custodial parent/legal
(Name of Custodial Parent/Guardian)

guardian for _____, a minor child. As of _____, I am requesting
(Child's Name) (Date)

services, on behalf of the child, from **Sierra Counseling & Mediation, LLC** and willingly give
permission for **Sierra Counseling & Mediation, LLC** to treat the above named minor child.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken. This consent, unless I revoke it earlier in writing, expires upon:

(Date, Event or Condition)

(Client's Signature)

(Date)

(Witness' Signature)

(Date)

(Signature of Parent/Guardian/Authorized Representative)

(Date)

NOTICE TO RECIPIENT OF DISCLOSED INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent from the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.