Dr. Corey Gilbert, PhD, LPC, PA-ABCST, CFTP
Professional Counseling, Coaching & Speaking Services
HealingLives, LLC

Consent for Counseling of Minors

Minor's Name _____

Date of Birth _____

This is to certify that I give permission to HealingLives Ministries for treatment of my child as his/her parent or legal guardian.

This counseling is in adherence to the Authorization for Counseling Services Agreement Form.

This counseling may include referrals to other appropriate State and County or professional agencies for further counseling.

_____ _____
Signature of Parent/Guardian **Date**

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City/State/Zip

_____
Phone

_____ _____
Therapist Signed / Title **Corey J. Gilbert, Ph.D., LPC** **Date**

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