Good Counsel
Child Confidentiality Agreement

Today's Date _____/_____/_____ Counselor: _____

Child's First Name _____ Last Name _____

PARENTAL INFORMATION

First Name _____ Last Name _____

Address _____City _____ State _____ Zip_____

(If two signatures required)

First Name _____ Last Name _____

Address _____City _____ State _____ Zip_____

I, being the father/mother with full legal right, give consent to the counselor (named above), to perform clinical therapy with my child (named above). I agree that my child should be able to talk freely without concern over his/her conversation during counseling being revealed to anyone. I understand that in order to acheive successful counseling, it is necessary for the patient to feel that his/her counseling experience will be totally confidential.

I further agree that I will not be entitled to any information discussed in counseling session unless my child gives his/her consent. In keeping with this desire to maintain confidentiality, I agree that the counselor shall not be called as a witness in any case involving the parent or the child. The counselor will not be required at any time to reveal the confidences of the child unless the child agrees in writing.

The only exception to this agreement of confidentiality is in the areas of illegal conduct, child abuse, or activities that involve danger to the child or another person.

I am entering into this agreement voluntarily and in the best interest of my child.

_____ _____

Print Name Print Name

_____ _____

Signature Signature