Counseling Services

Parental Consent for Treatment of a Minor

Name of Student: _____
(*Please print student name)*

Name of Parent / Legal Guardian: _____
(*Please print name of Parent / Legal Guardian*)

I hereby give consent for my son / daughter, _____,
(*Print student name*)

to receive psychological services at Counseling Services at the University of Nevada.

I understand that all communications between my son/daughter and his/her therapist are private communications and shall remain confidential. I also understand that if the therapist believes that my son/daughter is any danger to himself/herself or others I will be contacted right away. I also understand that there are several other important legally mandated exceptions to confidentiality.

These include:

- the clinician must report any incidence of suspected elder or child abuse, neglect, or maltreatment in order to protect the elderly and/or children involved; and
- in legal cases, clinicians or clinical records may be subpoenaed by a court order.

Other than the above-specified situations, I understand that communications between my son/daughter and his/her therapist will remain confidential and not be disclosed without my son/daughter's written authorization to do so.

_____ _____
Signature **Date**

Once completed and signed, please fax to Counseling Services at **(775) 327-2293**

Counseling Services
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University of Nevada, Reno / Mailstop 0080
Reno, NV 89557
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Fax: (775) 327-2293
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