



422 E. Vermijo Ave. Suite 211
Colorado Springs Co 80903
(719) 231-8746

**PARENT/GURARDING AUTHORIZATION FOR
COUNSELING SERVICES FOR A MINOR**

I, _____ and _____, do hereby grant my
permission for my child, _____, whose birth date
is _____, to be seen for counseling purposes by Robert Course. I
understand that the counseling session will be confidential and that no
information or records concerning those sessions will be divulged to any person,
including parents or legal guardians, without the prior consent of the individual
receiving counseling services and his/her counselor or pursuant to the laws of the
state of Colorado.

Parent/ Guardian Signature:

Witness Signature:

Date: ____/____/____

Date: ____/____/____