Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B
Towson, MD 21204
443.535.3130

Consent To Treat A Minor

I, _____, give Carolyn Karoll LCSW-C, permission
Parent/Legal Guardian's name

to provide mental health treatment to _____.
(minor child's name and date of birth)

In cases when there is a separation and/or divorce: A second form must be completed and **THIS FORM MUST BE ACCOMPANIED BY A LEGAL PARENT AGREEMENT AND/OR CUSTODY PAPERS on the first visit.**

If you do not have any legal documentation, both parents need to sign/consent to treatment.
Please check one:

__ I am the parent with sole legal decision making power.
__ I share legal decision making power with
_____.
Co-Parent's name and phone number

__ I do not have legal decision make power.
STOP: Your child cannot be treated unless the parent who holds legal decision making rights gives permission.

On this date, **I have sole legal rights to make decisions** on behalf of my child and the other parent (check one)

__ is aware

__ is not aware that our child is in therapy. (If not, please explain why).

On this date, the other parent **who I share legal decision making rights with** (check one):

__ is aware

__ is not aware that our child is in therapy. (If not, please explain to the counselor why).

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of parent/guardian Date

_____ _____
Therapist's signature Date