



**Parental Consent for Treatment of a Minor
Kennesaw State University
Counseling & Psychological Services**

I hereby give consent for Kennesaw State University Counseling & Psychological Services to provide individual counseling, group counseling, and/or psychiatric consultation to my minor son/daughter.

Name of Student: _____

Student KSU ID# _____

I understand that:

- My son/daughter has the right to refuse diagnostic or treatment services
- Any specific information, which my son/daughter shares in counseling, will be treated with the strictest confidentiality. I also understand that there are important legally mandated exceptions to confidentiality. These include the following:
 - Notification of relevant others when a clinician judges that a client is in immediate danger to self or others, as for example, in the case of suicide or homicide;
 - 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 judge.
 - Or minor student is engaging in behaviors that could foreseeably cause serious harm or death.
- I further understand that confidential information will not be disclosed without my son/daughter's written authorization to do so.

I agree that a photographic copy of this authorization will be as valid as the original.

Printed Name of Parent or Guardian

Signature

Date
