momentum
mental health

Consent for Counseling of Minors

Name of Parent/Guardian: _____

Name of Minor: _____ DOB: _____

Name of Counselor: Robin Darbonne License Type: Colorado LPC

This is to Certify that I give Robin Darbonne, M.A., LPC consent for treatment of my child. This counseling may include play therapy, family therapy, or referrals for psychological or psycho-educational testing. This counseling may also include referrals to other appropriate state, county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone: _____

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