GREENECARE COUNSELING

Elise K. Greene, LCSW, PO Box 975, 302 S. Locust Street, Ste 3, Floyd, Virginia 24091
(ph) 540-745-4700 (fax) 540-745-4706

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Minor's Name: _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling from the professional staff associated with GreeneCare Counseling.

The mental health provider responsible for care, Elise Greene, LCSW, agrees to explain to me the proposed treatment plan and treatment options.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification. Any questions relating to this form or the proposed treatment can be directed to Elise Greene, LCSW, GreeneCare Counseling at 540-745-4700.

Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____

Date: _____