The Door – A Center of Alternatives, Inc.
Counseling Center

MENTAL HEALTH SERVICES
CAREGIVER CONSENT FORM

Child's Name (First & Last Name): _____ Date of Birth: _____

Permission is granted for (print first & last name), _____
to receive mental health services provided by a licensed clinician and support staff of the Counseling Center of The Door – A Center of Alternatives, Inc.

Mental health services may include:

- Individual mental health counseling
- Walk-in crisis appointments
- Psychiatry services
- Referrals for specialty services, procedures, testing and treatment

I agree to the above services.

☐ Yes

☐ No, except for: _____

I would like to be notified before my child receives any medications onsite.

☐ No

☐ Yes, contact me at the following phone number: _____

I understand that all information will be kept confidential, or if a consent is signed by me which allows the health center to release my child's records. I have read and understand the above information. This consent will remain in effect unless and until I cancel it in writing.

Legal Guardian Name (Print): _____ Relationship: _____

Legal Guardian Signature: _____ Date: _____

Witness Signature/Title: _____ Date: _____