Lincoln Counseling Center

Yvonne Sinclair M.A., LMFT #MFC35807
898 5th Street, Suite B Lincoln, CA 95648
916-434-2877 FAX 855-775-7457

PSYCHOTHERAPY TREATMENT AUTHORIZATION

Authorization is hereby given for psychotherapy treatment for my minor child

_____
Name of Minor Child

*I understand everything said in session is confidential by California law. Parents are also excluded in this confidentiality law. If information is given parents should know, the therapist and the client will work out how to tell the parent.
*I understand there are exceptions to this law as follows;

If child abuse is suspected
If elder abuse is mentioned
If client is in danger of harming self, others, or others property
If client is unable to care for self (if a minor, minor is living independently)

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Signature Date

*I understand I must sign an authorization for exchange of ANY information, so the therapist may communicate with individuals outside of this office. Those "others" may include teachers, doctors, previous therapists, and/or another parent or caregiver.
*I understand this authorization can be changed and/or revoked in writing at any time.

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Authorization is hereby given for the exchange of relevant information regarding the above mentioned minor client between Yvonne Sinclair M.A., LMFT and ;

_____

_____

_____
Parent/Guardian Signature date

_____
Parent/Guardian Signature Date