Lora Hoffstetter Counseling and Associates, LLC

77 Milford Drive, Suite 218, Hudson, OH 44236

CONSENT FOR TREATMENT OF A MINOR OR ADULT WITH GUARDIAN

I, _____ grant permissions to _____
(Parent/legal guardian name) (Clinician)

Who is an affiliate of Lora Hoffstetter & Counseling Associates, LLC to render the service or treatment necessary to _____.The service or treatment is to include care essential for the
(Client Name)
client's condition. All treatment or any changes in treatment will be discussed with said parent/guardian.

Signed: _____

Relationship to Patient:_____

Date: _____

Witness to Signature: _____

Please list contacts whom we **may** communicate with.

1.) _____, _____
(name) (relationship)
2.) _____, _____
(name) (relationship)
3.) _____, _____
(name) (relationship)

Please list contacts whom we **may not** Communicate with.

1.) _____, _____
(name) (relationship)
2.) _____, _____
(name) (relationship)
3.) _____, _____
(name) (relationship)