Harriet Kohen, MA, MSW
Licensed Independent Clinical Social Worker
10505 Wayzata Boulevard, Suite 200 Minnetonka, MN 55305
763.546.5797

Consent For Treatment of a Minor

I agree to therapeutic services provided to my minor child by Harriet Kohen, LICSW at this office.

Client's name: _____

Address: _____

Parent(s)/Guardian(s) Signature: _____

Address (if different than client's address):_____

Date:_____

I/we understand that I/we have the right to information concerning my minor child in therapy, except where otherwise stated by law. (Minnesota Stat 144.341-342 except when the minor is married, legally emancipated or has borne a child, or when information in the records concern venereal disease, chemical dependency, or pregnancy-related conditions. Minnesota Statute 144.343).

I also understand that this therapist believes in providing a minor child with privacy in which to disclose her/himself to facilitate therapy. I, therefore, give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed to me, or by my child is to be shared with me. (Minnesota Statute 144.335 subd 2)

Parent(s)/Guardian(s) Signature:

_____

Date:

_____