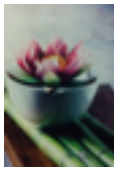

Akira Stuckey, MA, LCMHC
155 Washington St.
Keene, NH 03431

603-439-7711
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Consent for Treatment - Minors

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request the written agreement below from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, I will provide them only with general information about our work together, subject to your approval, unless I feel it is important for them to know something in order to make sure that you and people around you are safe. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

I/we _____
give my/our consent that Akira Stuckey conduct psychotherapy with
(minor) _____._____
My/our relationship to the client (parent, guardian, etc.): _____

I have been notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Akira Stuckey's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well being.

_____

Adult Name (print) Relationship Signature Date

_____

Adult Name (print) Relationship Signature Date

_____

Minor Name (print) Signature Date