Danisha Reed, LPC, ACS

Serving Atlantic County

609-447-2419

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CONSENT AGREEMENT FOR COUNSELING OF MINORS (Age 17 and under)

This is to certify that I give permission for the minor named below to participate in counseling provided by SUGAR Counseling, LLC. I understand and agree that the minor's counseling records are kept confidential, except where disclosure is required by law (neglect/child abuse reporting requirements, serious threat of harm to self or others) or the minor has signed the appropriate release of information forms.

Name of Minor _____

Minor's Date of Birth _____

Name of Parent/Guardian_____

Signature of Parent/Guardian _____Date _____

Street Address _____

City/State/Zip _____

Home Phone _____ Work/Cell Phone _____

Emergency Contact (other than yourself) _____ Ph. _____