If you are under the age of 18, Texas State Law requires that we obtain permission from your parent or managing conservator/guardian in order to offer you counseling services/psychiatric treatment, unless any of the following circumstances apply (please check all that apply).

According to Family Code 32.003, treatment by a licensed physician can occur if:

- I am on active duty in the armed forces OR
- I am 16 years of age or older and reside apart from parents, conservator, or guardian AND I manage my own financial affairs (regardless of the source of income).

If you checked one of the 2 above items, we can offer you psychiatric treatment without parental/guardian consent.

According to Family Code 32.004, consent for counseling can occur when:

- I am thinking about suicide.
- I have concerns about alcohol and/or drug addiction or dependency.
- I have been sexually, physically, or emotionally abused.

If you checked one of the 3 above items, we can offer you counseling without parental/guardian consent.

If none of the above situations apply and you are a minor between 16-18 years of age, Texas State Law requires you request outpatient mental health services from the administrator of the facility:

- In accordance with Health and Safety Code 572.001(a), I hereby voluntarily request outpatient mental health services from the administrator of this facility.

If the above statement does not apply to you, then we will need parental/guardian consent before your counseling begins. Please obtain written permission from your parent or managing conservator/guardian for counseling services before an appointment is scheduled.

Under Texas State Law, parents/guardian may still have access to your counseling/psychiatric record and/or could talk with your counselor/psychiatrist whether parental consent is necessary or not. A counselor/psychiatrist may contact a parent/guardian without consent, if deemed necessary.

By signing this Consent Form, I am acknowledging that:

1. I have read this form and understand its contents, including the limits of confidentiality stated above.
2. The information I have provided is accurate.
3. I request counseling services from the Counseling & Mental Health Center.

STUDENT NAME (PLEASE PRINT)

STUDENT SIGNATURE

DATE

UT EID

WITNESS SIGNATURE

DATE

STUDENT NAME (PLEASE PRINT)

STUDENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

ADMINISTRATOR SIGNATURE

DATE

Counseling and Mental Health Center

& University Health Services