Consent for Treatment of a Minor

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
- 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

WITNESS SIGNATURE  DATE

ADMINISTRATOR SIGNATURE  DATE