

**Hope Wilson, PCC, LICDC**

**PERMISSION TO SEE A MINOR**

I, \_\_\_\_\_  
(Custodial Parent/Legal Guardian)

do hereby attest that I am the legal, custodial parent/ legal guardian for

\_\_\_\_\_  
(Child's name)

I am requesting services on behalf of the child, from Hope Wilson PCC, LICDC, and willingly give consent for Hope Wilson PCC, LICDC to treat the above named child.

\_\_\_\_\_  
(Signature of Parent/Guardian) (Date)

\_\_\_\_\_  
(Address) (City) (State) (Zip)

\_\_\_\_\_  
(Home Phone) (Work Phone)

\_\_\_\_\_  
(Witness) (Date)

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**WAIVER OF RIGHT TO ACCESS CHILD'S COUNSELING INFORMATION**

I (We) understand that my child's therapy will be confidential and that it is important for the therapeutic process and my child to have the same rights of confidentiality in counseling as if he/she were an adult. I (We) recognize that I (we) have the legal right to request any information about this counseling but I (we) am (are) willing to give up the right to access this information.

\_\_\_\_\_  
(Signature of parent/legal guardian) (Date)

\_\_\_\_\_  
(Signature of parent/legal guardian) (Date)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Witness) (Date)

I am aware that my parent(s) or guardian has given up the legal right to access information related to my counseling. I further understand that this means I will have confidentiality in my counseling, as if I were an adult.

\_\_\_\_\_  
(Signature of client - minor) (Date)

**PROVISIONS FOR SERVING AS A CHILD THERAPIST  
FOR LITIGATING PARENTS**

It is important to note that Hope Wilson Counseling is NOT a forensic therapy office, nor provides, evaluates, or makes recommendations in custody and visitation issues. If a Guardian Ad Litem (GAL) is involved, I will communicate after the appropriate releases are completed.

When separating and/or divorced parents – who are involved in litigation – bring or have their child in therapy, there may be a risk regarding the child’s therapy. Specifically, if the therapist is asked to participate in any way in the litigation, the therapy may be seriously compromised. Effective child psychotherapy is best accomplished when both parents have a good relationship with the therapist. Information that the therapist provides to the court is likely to benefit one parent at the expense of the other. The parent whose position is weakened by this information cannot but harbor animosity toward the therapist, and such hostility toward the therapist is likely to compromise significantly the child’s treatment.

In order to prevent such deterioration of the child’s therapy it is crucial that I have every reassurance that there will be absolutely no involvement on my part in the litigation between the parents. This is best accomplished by both parents signing this statement:

We wish to enlist Hope Wilson, PCC, LICDC’s services in the treatment of our child \_\_\_\_\_ . We recognize that such treatment will be compromised if information revealed therein may subsequently be brought to the attention of the court in the course of litigation.

Accordingly, we mutually pledge that we will neither individually nor jointly involve Hope Wilson, PCC, LICDC in any way in the litigation. We will neither request nor require that Hope Wilson, PCC, LICDC provide testimony in court, either as an advocate or as an impartial. We will neither request nor require that Hope Wilson, PCC, LICDC provide written reports of the treatment because such documents might ultimately be used in the litigation. We will not permit Hope Wilson, PCC, LICDC to communicate with either of our attorneys in any manner, either verbally or in written form. In short, we will strictly refrain from involving Hope Wilson, PCC, LICDC in any litigation – in any way whatsoever, either directly or indirectly.

If the services of a mental health professional are considered desirable for the purposes of litigation, either as an advocate or as an impartial, the services of another person other than Hope Wilson, PCC, LICDC, will be enlisted.



We have read the above, discussed these provisions with our attorneys, and agree to proceed with the therapy.

(Date)	(Signature)	(Witness)
(Date)	(Signature)	(Witness)
(Date)	(Signature)	(Witness)

Please sign here if spouse is deceased: \_\_\_\_\_ (Date)