Michael J. Maxwell, PhD, LPC, NCC

Licensed Professional Counselor

250 N. Mill St., suite 5

Lewisville, TX 75057

Consent For Treatment Of Minor(s) & Others

I ________________________ give my consent that Dr. Michael J. Maxwell will be conducting psychotherapy with (name of minor): ________________________________.
My relationship to the client (parent, uncle, etc.): ________________________________ .
I was notified that the holder of the privilege is (parent, guardian, etc.) ____________________ .

I was also 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, which I have read and signed.

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 Dr. Michael J. Maxwell's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

Name (print)	Relationship	Signature	Date
______________________	______________________	__________________	__________
______________________	______________________	__________________	__________