**PARENTAL CONSENT FOR**

**FAMILY THERAPY**

Colorado Legal Statue regarding parental consent for the mental health treatment of minors limits such privilege to the parent(s) who holds “allocation of parental responsibility”. In cases where the child(ren)’s parents are divorced or legally separated, the Crisis Center is responsible and liable; to ensure that the parent seeking treatment for their child has the legal “parental responsibility” to consent for the mental health treatment.

With regards to my child(ren): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By signing this consent, I am stating I have: ***(Please check one of the following)***

\_\_\_\_\_\_\_\_ sole legal parental responsibility for the care and medical decision-making regarding my child(ren).

\_\_\_\_\_\_\_\_ shared legal parental responsibility for the care and medical decision-making regarding my child(ren).

Please be informed, that if you share “parental responsibility” with the child’s other biological parent/legal guardian, ***we must obtain consent for treatment from that parent/legal guardian prior to providing individual, group or family counseling services***.

I understand that I must bring a copy of any pertinent legal documentation stating “allocation of parental responsibility”, such as, a divorce decree, legal separation documents, temporary/permanent orders or custody paperwork to be included in the clinical file. I will also notify the Crisis Center of any changes or updates regarding “allocation of parental responsibility” and will provide copies of documentation supporting those changes as this could impact my child(ren)’s ability to receive counseling services at the Crisis Center.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crisis Center Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_