Sarah Swenson, MA, LMHC
Swenson Counseling Services
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PARENT OR GUARDIAN CONSENT FOR SERVICES TO A MINOR

I/we _____
(print name/names)

Parent/Legal Guardian of _____
(print name)

voluntarily give consent for him/her to receive counseling/psychotherapy services with Sarah Swenson, MA, LMHC.

I/we understand that I/we may decide at any time to decline consent for the continuation of these services, and that I/we will inform Sarah of this decision as soon as possible.

I/we agree to work cooperatively with Sarah as needed. I/we have adequately discussed with Sarah any questions I/we have about any aspect of the services.

_____

Sarah Swenson, MA, LMHC Date