Brian Jensen, Ph.D.
www.DrBrian-Jensen.com

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CONSENT FOR TREATMENT FOR MINOR/S

I ____

give my consent that Dr. Brian Jensen, Ph.D., will be conducting counseling/psychotherapy

with ___________________________.__________________________________

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 case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Brian Jensen's (therapist) judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

____________________	________________	_______________	________
Name (print)	Relationship	Signature	Date

____________________	________________	_______________	________
Name (print)	Relationship	Signature	Date

Brian Jensen, Ph.D.
145 S. Washington Street STE I
Sonora, CA 95370

Licensed Marriage & Family Therapist, MFC 40118
Licensed Professional Clinical Counselor, LPCC 806
Certified Clinical Mental Health Counselor, 57654
APA Certified PTSD Clinician, 15879
National Board Certified Counselor, 57654