



Louisville Seminary Counseling Center
Permission to Counsel a Minor

Date _____

Minor Client: _____ Date of Birth: _____

Parent/Legal Guardian: _____

I give permission to Louisville Seminary Counseling Center to provide counseling services to my child,
_____.

Limits of Confidentiality

I understand that all Counseling Center staff adhere to strict confidentiality standards according to Kentucky Law. I understand that while my child is a minor, I have rights to discuss my child's counseling with her/his counselor. Information discussed in the therapy setting is held confidential and will not be shared legal authorities without written permission from a parent except under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s).
3. The client reports suspected abuse or neglect, including but not limited to, physical and/or sexual abuse of a child, of the elderly, or of a spouse.
4. The client reports sexual exploitation by a therapist.
5. There is issuance of an order by a court.
6. The client has granted permission.

Therapists at LSCC receive supervision and participate in team consultation that is an additional benefit of receiving services in an educational institution. Therapy sessions are discussed as deemed necessary with supervisors and other staff at the Louisville Seminary Counseling Center and with faculty and professional colleagues at the Louisville Presbyterian Theological Seminary. Identifying client information is kept confidential during such consultation.

Parent/Guardian Name

Parent/Guardian Signature

NOTE: This form **must be notarized if not completed at
Louisville Seminary Counseling Center. (See back of form.)**



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Seminary Witness:

Today, _____, parent/guardian of _____
validated the identification of the person who signed the preceding or attached document.

LSCC Witness

Date