Libby Howell, Ed.D.

5410 S Lakeshore Drive, #103
Tempe, AZ 85283
480-756-8686
480-756-8918 FX
AZ License #1935

CONSENT FOR COUNSELING A MINOR

Child's Name:_____Date of Birth:_____

I/We, _____the undersigned parent(s) or guardian(s) of the herein identified minor named above, do hereby authorize and give my/our written permission for said minor to be entered into counseling with Libby Howell, Ed.D., LMFT. It is understood that this consent is subject to revocation by the undersigned at anytime except to the extent that action has already been taken in that consent.

My/Our signature below also verifies that I/we are the legal parent(s) or guardian(s) of the above mentioned minor and have the legal right to consent for said minor to receive treatment from Libby Howell, Ed.D., LMFT.

Parent/Guardian Name (printed):_____
Address:_____
Telephone: HM_____ CL _____

Parent/Guardian Signature:_____Date_____

Parent/Guardian Signature:_____Date_____

Witness Signature:_____Date_____

In accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA) this fax/email/document, including any attachments, may contain confidential and privileged information, and is for the sole use of the intended recipient(s). Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply email or fax and destroy all copies of the original message.