Counseling Services
Written Informed Consent for Treatment

Parent/Guardian Complete the Following

I, _____ (Parent/Legal Guardian), grant Minot State University Counseling Center permission to provide mental health services for my student, _____ (Student's name),

DOB ___/___/___, currently a minor/under guardianship, and enrolled at Minot State University. I further give Minot State University Counseling Center permission to contact my student's previous mental health care providers regarding past treatment.

By signing below, parent/legal guardian understands that the clinic will make no effort to notify them for further consent related to services after the receipt of this consent.

This written authorization may be withdrawn at any time by extending an online request and/or by providing notice in writing to:

Minot State University
Student Health Clinic
500 University Avenue West
Minot, North Dakota 58707

Phone: (701) 858-3371 Fax: (701) 858-3997

_____ _____

Parent/Legal Guardian Signature **Date**

*** Telephone Verbal Consent Obtained / Official use only***

Client (Print): _____

Client (Signature): _____

Date: _____ Date of Expiration: _____

Witness: Witness: