Teresa Khouw, MA, LPC, RPT
Child Centered Counseling
www.ChildCenteredCounseling.net
972 365 8165

I, _____ (parent or legal guardian),

give my consent and permission for counseling sessions to be conducted with

_____ (child's name).

I am aware that my child's counseling sessions may be video and audio recorded. _____ (initial)

I am also aware that my conversations and/or sessions with the counselor may be

video and audio recorded. ____ (initial)

These recordings along with all materials and matters discussed during counseling are

confidential and private and will not be released without my written permission.

_____ _____ _____

Signature Date Relationship to Minor