COVENANT
FAMILY SOLUTIONS

Co-Parenting Consent Form

The purpose of this letter is to inform you that your child, _____, is receiving mental health services at Covenant Family Solutions. If you have questions or concerns about these services or authorization rights, please contact their therapist, _____, at (319) 261-2292 ext. _____.

This will be the only notice sent informing you of consent to therapy services. However, you may contact us at any time if you have questions, concerns, or information deemed appropriate for assessment and/or treatment. Collaboration between caregivers and a child's therapist is often a valuable tool in making therapeutic gains and progress.

Thank you

_____

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In the state of Iowa both parents need to be aware of treatment of a minor. Please provide information to allow us to contact the other parent. We will make an attempt to notify of services, outline rights for authorization, and ways to contact therapist if needed. If they do not reply, services will not be impacted.

Name: _____

Address: _____

Telephone: _____

Have you discussed this therapy with them? ____ No ____ Yes

Are there any concerns we should be made aware of?

_____

_____

_____

1655 Blairs Ferry Rd. Marion, IA 52302 Phone 319.261.2292 Fax 319.200.2516