



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, please contact their therapist, _____, at ____-____-____. Please sign and return the bottom of this letter within 14 days to 1655 Blairs Ferry Road, Marion, IA 52302 or directly to the Covenant Family Solutions office where your child is receiving care. If we do not receive this, we will assume that you consent to treatment.

Thank you

Return form to:
Covenant Family Solutions
1655 Blairs Ferry Road
Marion, IA 52302

I, _____, the parent of _____, wish to inform you that I do not consent to mental health services by Covenant Family Solutions. Please discontinue treatment.

Signature

Date

In the state of Iowa both parents need to consent for the treatment of a minor. Please provide information to allow us to contact the other parent. We will send them a letter informing them of services and giving them an opportunity to deny consent. If they do not reply, services will continue.

Name: _____

Address: _____

Telephone: _____

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

Are there any concerns we should be made aware of?

