Dakota Children's
ADVOCACY CENTER

Telehealth Outreach Program
Clinical Consent for Treatment

Client Name: _____ **Date of Birth:** _____

I, _____, the Parent/Legal Guardian of _____, give my consent for my child, named above, to receive mental health services from the Dakota Children's Advocacy Center's Telehealth Outreach Program. I understand that the information which my son/daughter shares with the counselor is confidential and can be shared with me only at the counselor's discretion and/or if my child is assessed to be at risk of harming him/herself or others or discloses on going past abuse or neglect. Care will be provided in a private manner and information will not be released without my consent. I allow mental health providers to provide necessary and/or advisable treatment for my child. I understand that supervised interns may assist in my child's care.

I hereby release DCAC, its personnel and any other person participating in my care for any and all liability, which may arise from the taking and authorized use of such digital recording films and photographs.

I understand this consent form is valid, until I revoke it.

_____

Signature of parent/guardian Date

_____

Printed name

_____

Witness