Consent for Treatment

I certify that the information provided on the intake form is correct to the best of my knowledge. Furthermore, I intend to voluntarily enter treatment and recognize that my therapist may recommend that I engage other professionals such as psychiatrist and primary care provider.

AJ Counseling Services LLC shall treat all information being furnished from records as confidential. Release of information concerning my therapy to any other agencies shall only be made after I have given my approval in writing. The authorization and consent to release information from my record shall remain in effect for a period of no longer than one year, but is subject to written revocation by me at any time.

I have read and understand this agreement and have voluntarily execute

X	X
Client Name (Print)	Signature
X	X
Name of Parent/Guardian (Print)	Signature of Parent/Guardian
X	X
Printed name of Witness	Signature of Witness