

Name of Parent/Guardian: _____

Name of Minor: _____ DOB: _____

Name of Counselor: _____

This is to certify that I give Kelly Johnson consent for the treatment of my child. This counseling may include individual therapy, family therapy, or referrals for psychological testing. This counseling may also include referrals to other appropriate state, county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone: _____

*Colorado Center For Healing And Change
2323 S Troy St, Building 1, Ste. 310
Aurora, CO 80014*