

# C.R.E.A.T.E!



The Center for Expressive Arts, Therapy and Education, P.L.L.C.

As the parent/legal guardian of:

Name: \_\_\_\_\_

I give my consent for my minor child to receive treatment from:

THERAPIST: \_\_\_\_\_

1. The purpose of treatment is to promote and foster our child's best interests.
2. The counseling will be guided by our child's best interests.
3. We acknowledge that our child will have a confidential relationship with the THERAPIST.  
NH RSA 330-A:32
4. To the extent that our child directs and/or to the extent that the Therapist believes that it is in the best interests of my child, the THERAPIST shall protect and safeguard the child's rights of privacy, privilege and confidential relationship with the THERAPIST even as to our own parental inquiries and requests for information.
5. We agree that any disclosure to us by the THERAPIST of confidential information is not a waiver of child's rights of privacy, privilege or confidential relationship and will not give us access to other information regarding our child's treatment with the THERAPIST.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Printed Name

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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