TRUTHERAPY

P: (706) 843-6141
F: (706) 843-6242
PO BOX 7660
North Augusta, SC 29861

School Authorization Form

I, _____ (PARENT/LEGAL GUARDIAN NAME), the parent/legal guardian of _____ (CLIENT'S NAME), give permission for mental health providers at Trutherapy LPC to provide counseling and other related services for my child at _____ (NAME of SCHOOL). They also have permission to meet with teachers and other school officials to discuss my child.

I also give _____ (NAME OF COUNSELOR) permission to pick-up my child from school in order to provide the services he/she needs.

If you have any questions or concerns please feel free to contact me at:

_____ (PARENT/GUARDIAN CONTACT NUMBER)

_____ _____
Parent/Guardian Printed Name Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature & Credentials Date