Ashleigh Bryan, MS, LMFT
5200 Park Rd, Ste 111
Charlotte, NC 28209
704-607-1393

I, _____ as the legal custodial guardian of _____,
(parent/legal guardian) (minor child)
hereby give my permission for _____ to be seen by
(minor child name)
Ashleigh Bryan, MS, LMFT, for counseling services. I understand that all information shared in these counseling sessions will remain confidential with the exceptions of the following:

1. Your child is evaluated to be a danger to themselves or others
2. Your child is believed to be the victim of abuse or your child reports such abuse.
3. A court order or other legal proceedings or statute require disclosure
4. Your insurance company requires information in order to pay claims.

I understand that Ashleigh may contact me in order to discuss issues related to my child and that I am able to contact her in regard to any questions I may have, with the understanding that she will share only what she believes to be in the best interest of your child.

By signing below I acknowledge that I have had the opportunity to ask any questions I may have on limits of confidentiality and that I have read and signed the Professional Disclosure provided to me as well.

_____ _____
Parent/Legal Guardian Signature Date

_____
Parent/Legal Guardian Name Printed

_____
Address

_____
City State Zip

_____ _____
Home Phone Work Phone

_____
Cell Phone

_____ _____
Therapist Signature Date