

STELLA KAVOUKIAN MSW, RSW

I consent to my child(ren) participating in closed therapy sessions with Stella Kavoukian. I understand that the purpose will be to provide support for my child(ren) and as such all of the sessions between Stella Kavoukian and my child(ren) will be considered confidential. I agree that none of the information obtained or discussed during the course of the therapy may be used outside of the therapy sessions and will not be used in any Court proceedings.

I understand that Ms. Kavoukian nonetheless has a statutory obligation to report to the appropriate child welfare authority and/or other relevant authorities if she has a reasonable suspicion that my child(ren) is in danger of harm; or of harming himself/herself, or another person.

I acknowledge that:

- I waive my right to subpoena Stella Kavoukian, her records, notes, correspondence or similar documents relating to the therapy at any time during or subsequent to the therapy.
- All communication during the course of therapy is confidential and will not be used in any Court proceedings.

Names of children and DOB:

I am signing below to indicate that I read, understood, and agree to the terms outlined above.

Date: _____

Date: _____

Parent's Name: _____

Parent's Name: _____

Parent's Signature: _____

Parent's Signature: _____

Signed: _____

Signed: _____

Witness Name: _____

Witness Signature: _____