

**SYRACUSE UNIVERSITY**  
**COUNSELING CENTER**



Dear Parent/Guardian,

Your student has expressed interest and/or has been referred to the Syracuse University Counseling Center for counseling services. The Counseling Center offers a variety of psychological services including brief individual counseling, crisis intervention, and general consultation.

Please be advised that the nature of the counseling relationship is one based on confidentiality. Information shared by your student in a counseling session will be treated with the strictest confidentiality unless, in the judgment of our staff, disclosure of information is necessary to protect your student from imminent physical danger. It is in the best interest of your student if you, as the parent, respect the confidential nature of the relationship. As you know, it is difficult to engage in a therapeutic process with a student if they feel information will be shared. Please be aware, however, that we will make every effort to encourage your student to include you in the process in a way that is most meaningful to him/her.

If counseling for your student is agreeable to you, please sign the attached parental consent form. Please feel free to contact us if you have any questions.

Thank you very much.

Sincerely,

Cory Wallack, Ph.D.  
Director, Syracuse University Counseling Center



**Parental Consent Form**

Students who are under the age of 18 are required to obtain signed consent from a parent or guardian giving the Counseling Center permission to initiate counseling.

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ (Student's name), do consent to them receiving counseling at the Syracuse University Counseling Center. I understand that this counseling is not mandatory but may be in their best interest.

*(Please print)*

Student's Name: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

Notary witness: