INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____ Date of Birth _____

I understand that all information shared with my therapist is confidential and no information will be released without my consent. In all circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

If I have any questions regarding this consent form I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me. I understand that I may stop treatment at any time.

_____ _____
Signature Date

_____
Therapist Name

_____ _____
Therapist Signature Date