INFORMED CONSENT FOR COUNSELING SERVICES

Client's Name _____

Date of Birth: _____

Parent's Name(If Client is a Minor) _____

As the client/parent/legal guardian, I give my informed consent to participate in assessment, service plan development, and/or counseling services. The frequency and duration of services will be determined based on the development of the counseling goals with the input of the client and/or family.

I understand that all information will be treated with strict confidentiality. No Protected Health Information (PHI) related to me or my minor child, either verbal or written, will be released to other agencies or individuals without the written consent. By law, the rules of confidentiality are limited under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is revealed or suspected, the counselor is required to report information to the Department of Children & Families.
2. If information is revealed regarding the threat of danger to self or others, the counselor has a duty to warn the potential victim and report information to the appropriate authorities.
3. If the counselor's records or testimony are subpoenaed by court order.

The information in this informed consent has been explained to me. I may revoke consent in writing for the above at any time. However, I cannot revoke consent for action that has already been taken. A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES ONE CALENDAR YEAR AFTER BEING SIGNED.

_____ _____

Client's Signature Parent or Legal Guardian Signature Date

_____

Witness Date