

## Parental Consent for Services

**Confidentiality**

For therapy to be effective, even within groups, confidentiality must be honored. No information will be shared with a party outside of services without your written consent. Additionally, all information shared in individual or group sessions will be held confidential. However, the goals and progress of the counseling may be shared with you, any other legal custodial parent or guardian. By law, confidentiality must be breached if a therapist or staff suspects that any minor is being or has been abused, if a person plans to physically harm another person, or if a person plans to harm him/herself. Additionally, breaching of confidentiality will occur if a therapist or staff hears that an elder or dependent adult is being or has been abused.

**Adolescent participant:**

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with services, you can ask your therapist at any time.

Youth's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian:**

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

I understand that I will be informed immediately about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Email: \_\_\_\_\_