

**INFORMED CONSENT AND  
AUTHORIZATION FOR SERVICES**

MY DECISION TO PARTICIPATE IN PSYCHOLOGICAL ASSESSMENT AND/OR PSYCHOTHERAPY INCLUDES CONSIDERATION OF THE FOLLOWING INFORMATION:

1. DISCUSSION OF THE PURPOSE, GOALS AND EXPECTATIONS OF ANY ASSESSMENT AND/OR TREATMENT PROCEDURE;
2. INFORMATION CONCERNING THE POTENTIAL RISKS AND BENEFITS OF TREATMENT AND ITS LIMITATIONS;
3. UNDERSTANDING AND ASSURANCE THAT INFORMATION DISCLOSED IN THE COURSE OF SERVICE DELIVERY WILL REMAIN CONFIDENTIAL EXCEPT IN THOSE CASES WHEN:
  - A. THE CLIENT OR GUARDIAN PROVIDES WRITTEN AUTHORIZATION FOR THE RELEASE OF INFORMATION TO A SPECIFIC PARTY FOR A SPECIFIC PURPOSE, OR
  - B. THE PROVIDER DETERMINES THAT THERE IS THE POSSIBILITY OF A CLEAR DANGER TO MYSELF OR ANOTHER PERSON OR PROPERTY, OR
  - C. THE PROVIDER, AS REQUIRED BY LAW, DEEMS THAT THERE IS REASONABLE CAUSE TO BELIEVE THAT A CHILD UNDER THE AGE OF 18 HAS BEEN PHYSICALLY INJURED, SEXUALLY ABUSED, OR NEGLECTED.

I UNDERSTAND THAT THIS CONSENT INVITES ME TO CONTINUALLY DISCUSS ANY OF THESE MATTERS OR ANY DECISIONS CONCERNING MY TREATMENT.

MY SIGNATURE REPRESENTS THAT I HAVE REVIEWED THE ABOVE INFORMATION AND THAT I AM VOLUNTARILY CONSENTING TO PARTICIPATE IN SERVICES.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(CLIENT)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(SPOUSE/PARTNER, IF COMING TO SESSION)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(GUARDIAN)