NORTH STAR COUNSELING CENTER

Limits of Confidentiality and Consent to Treatment

I understand that all information regarding the participants(s) names below is held in confidence and no information will be shared without written permission.

I also understand that confidentiality will not be maintained under the following conditions:

1. During consultations with the North Star director and staff.
2. If the participant or family member threatens suicide, the law permits the therapist to report this situation to a caring adult, a family member and/or proper authorities.
3. Where the client has communicated to the therapist a serious threat of physical violence against a reasonable identifiable victim or victims.
4. If the therapist has knowledge of or observed a minor child who the therapist knows or reasonably suspects has been a victim of child abuse, the law requires a report of the situation to the proper authorities.
5. If a client presents as a danger to self or others due to a mental disorder, the therapist has the option of arranging hospitalization pursuant to Welfare and Institutions 5150.

I have read this statement and understand the contents, which have been fully explained by the North Star Counseling Center intern. I agree to these limits of confidentiality and will not hold any of the North Star Counseling Center staff liable for breach of confidentiality under the conditions stated above.

In addition, I do hereby give my full consent for my minor child to be interviewed and receive counseling services from North Star Counseling Center. I understand that these services may be provided by counseling intern/trainees under the direct supervision of a licenses marriage and family therapist.

____

Participant's Signature   Date

____

Parent/Guardian Signature   Date

____

Parent/Guardian Signature   Date

____

Intern/Counselor Signature   Date

If my counselor believes that my substance use or other behaviors indicate a clear and present danger to my well-being, then I give permission for my counselor to share that information with my parents.

____

Client Signature (if under 18 years of age)   Date

I hereby give my permission for counseling sessions to be audited or recorded for the purpose of supervision of Counselor-Interns/Trainees. The above-stated protection of confidentiality applies to the use and/or reuse of recordings.

____

Participant's Signature   Date

____

Parent/Guardian Signature   Date