CONSENT TO EVALUATION, TREATMENT, AND/OR ASSESSMENT

Re: _____ Date of Birth: _____
(Patient's Name)

I am voluntarily choosing to have psychological treatment and/or evaluation and am aware of the goals, potential benefits, and limitations of such treatment or evaluation. I may terminate or request referral to another professional at any time. I understand that it is my right and responsibility to voice any concerns, objections, or doubts I might have regarding the course of treatment to the professional with whom I am in treatment.

I hereby acknowledge that I am 18 years of age or older, of sound mind and competent to consent to treatment for myself or others for whom I am parent or legal guardian. I further consent that any information gathered during the process of treatment and/or evaluation will be used for treatment planning. Information may also be used for training and future research purposes, at which point any and all identifying information will be removed.

I recognize that the relationship between the therapist and patient is unique in that confidentiality lies at the core of facilitating the services I receive. However, I also accept that there may be limits to maintaining confidentiality and these instances include the following four (4) areas:

(1) I understand that if my therapist is concerned for my safety such that her/she assess that I am a serious threat to hurting myself or someone else, he/she is obligated to protect me or any other party from hurt or harm. Under this very limited and rare circumstance I recognize that he/she will have to relay sufficient relevant information to necessary parties about me to ensure that I and/or others remain emotionally and physically safe and protected.

(2) I understand the treatment will be performed by graduate student in the Psychology Department, and that these students are under the supervision of licensed psychologists.

(3) I understand information may be released if subpoenaed or court ordered.

(4) I understand that my health information is also protected by the UDM Psychology Clinic Privacy Notice.

Signature of Client: _____

Signature of Parent/Guardian: _____
(If under 18 years of age)

Witness Signature: _____

Printed Name: _____

Date: _____

_____ I further consent to the use of audio taping should my therapist deem it beneficial to the
(Initials) therapeutic process.

_____ After my case is closed, I authorize Clinic personnel to contact me for follow-up
(Initials) assessment and possible involvement in future research.