TRUE SELF
COUNSELING SERVICES

CONSENT FOR TREATMENT-ADULT

I GIVE MY CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES FOR ME AND/OR MY DEPENDENT AT THE OFFICE OF **TRUE SELF COUNSELING SERVICES**.

THE NATURE OF THOSE SERVICES HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT ALL INFORMATION, INCLUDING VERBAL COMMUNICATIONS AND WRITTEN MATERIAL, IS TREATED WITH CONFIDENTIALITY.

CONFIDENTIAL INFORMATION WILL NOT BE RELEASED TO ANYONE WITHOUT THE WRITTEN PERMISSION OF THE CLIENT.

AS PROVIDED BY LAW, CONFIDENTIALITY MAY BE BREACHED FOR PROTECTIVE PURPOSES WHEN THE CLIENT IS IMMINENTLY A DANGER TO HER/HIMSELF, TO OTHERS, OR IN CASES OF SUSPECTED CHILD ABUSE OR NEGLECT.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

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