



CONSENT FOR TREATMENT FOR A MINOR

In order for us to provide this minor with mental health services, we must have your informed consent for treatment of this minor.

The Laws of California have been established to protect the privilege of confidentiality between a counselor and a patient, and Tulare County Mental Health Services protects the privilege of confidentiality, which belongs solely to the patient. Signing this form does not constitute a waiver of any psychotherapist-patient privilege. It is only under certain very special circumstances that this privilege of confidentiality does not exist:

1. We are required by law to report any suspected incident of child abuse (past or present), elder abuse or dependent adult abuse.
2. The law mandates that we notify others in cases where there is a threat of harm to oneself or others.
3. If we assess someone to be acutely suicidal, violent or homicidal, or unable to care for him/herself, we may notify appropriate authorities to arrange for hospitalization.
4. Our records may be subpoenaed by a court of law.
5. A court ordered psychological evaluation may be justified in the request for records.
6. A breach of a court order (e.g. a "no contact order", from a Temporary Restraining Order or a Violation of Custody Agreement) may justify a request for records.
7. There may be other circumstances in which a court may decide that the privilege does not exist.

We also want to inform you that the minor's mental health record will be maintained at Tulare County Mental Health Services. Our record keeping system, which may include computerized statistical, billing and treatment information, is designed to protect the minor's personal rights and insure confidentiality. However, in the process of providing the minor with services, there are limited number of individuals who will have access to the minor's records, including other County-funded mental health service providers who are or become directly involved in the minor's treatment. In order to provide the minor with services that are necessary to accomplish the purpose for which you have consulted Mental Health, the minor's case may be discussed with other counselors for supervision or consultation purposes. Other counselors consulted will maintain the confidentiality of privileged information provided by you. Clinic data, without clients, identifying information may be analyzed as part of our ongoing quality assurance and research.

I, _____, as _____ to _____
Name Relationship to Minor Name of Minor

(Who is _____ years of age), have read the above informed consent information and understand it. I hereby give my consent for treatment of the minor by Tulare County Mental Health Services and acknowledge the maintenance of the minor's records at Tulare County Mental Health Services.

 Signature of Parent/Guardian/ Conservator Or Patient (if 12 to 18 years of age) Date

 Signature of Witness Date

 Signature of other Parent Date

 Signature of Witness Date

cc: Consumer

Parent/s, please sign!



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_____ Signature of Parent/Guardian/ Conservator Or Patient (if 12 to 18 years of age)	_____ Date	_____ Signature of Witness	_____ Date
_____ Signature of other Parent	_____ Date	_____ Signature of Witness	_____ Date

cc: Consumer

Parent/s' Copy!