

# Guardian Consent Form

As the legal custodian/guardian of \_\_\_\_\_, a minor whose date of birth is \_\_\_/\_\_\_/\_\_\_\_\_, I am authorized to act on their behalf in making health care decisions.

I understand that the youth may receive various types of services provided by Youth Pride Inc. staff members, clinicians, interns, and/or volunteers. These services include but are not limited to individual psychotherapy, group support, and case management services. I understand that these services are available for free.

I have the right to revoke this authorization at any time. This authorization is valid until services are terminated, or until \_\_\_/\_\_\_/\_\_\_\_\_.

**CONFIDENTIALITY:** All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be shared with anyone outside Youth Pride Inc. without your written permission except where disclosure is required by law.

**WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW:** Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a youth presents a danger to self, to others, to property, or is gravely disabled, or when a youth's family members communicate to Youth Pride Inc. that the youth presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against the youth. If the youth's mental status is at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Youth Pride Inc. Staff at Youth Pride Inc. will use their clinical judgment when revealing such information. Youth Pride Inc. will not release records to any outside party unless you authorize us to do so.

**EMERGENCY:** If there is an emergency or when Youth Pride Inc. becomes concerned about the youth's personal safety, the possibility of the youth injuring someone else, or about the youth receiving proper psychiatric care, Youth Pride Inc. staff members and clinicians will do whatever they can within the limits of the law, to prevent the youth from injuring themselves or others and to ensure that the youth receives the proper medical care.

**CONSULTATION AND SUPERVISION:** Youth Pride Inc. consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. Unlicensed Youth Pride Inc. clinicians will be supervised by a licensed clinical supervisor and the youth's information may be discussed confidentially in supervision.

**RECORDS:** Both the law and the standards of the clinical profession require that Youth Pride Inc. keep treatment records for clients. If you have concerns regarding the treatment records, please discuss them with Youth Pride Inc., staff. As a guardian, you have the right to review or receive a summary of the youth's records at any time, except in limited legal or emergency circumstances or when Youth Pride Inc. assesses that releasing such information might be harmful in any way.

**COURSE OF THERAPY:** While the guardian can expect benefits from psychotherapy for the youth, they fully understand that no particular outcome can be guaranteed. Guardian understands that they are free to discontinue treatment of the youth at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so. The legal guardian of the youth has rights to general information about what takes place in therapy, to information about the youth's progress in therapy, to information about any dangers the youth might present to self or others, and, upon request, to obtain copies of the youth's treatment record (with certain qualifications and exceptions). The

guardian understands that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the youth and the psychotherapist.

**CONTACTING THERAPIST:** If you or the youth needs to reach their clinician outside of the clinician’s weekly hours, please contact a Youth Pride Inc. staff member and they will contact your clinician for you. If an emergency situation arises and the youth may not be safe, please call 911 or take them to the nearest emergency room.

**SOCIAL NETWORKING AND INTERNET SEARCHES:** Youth Pride Inc. clinicians and staff members do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, we request that clients not communicate via any interactive or social networking websites with individual clinicians, staff, interns, or volunteers.

**I have read the above information. I understand them and provide consent for the youth to participate in and receive individual psychotherapy, group support, case management, and other services at Youth Pride Inc.**

\_\_\_\_\_  
Guardian Name (please print) Signature Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

\_\_\_\_\_  
Relationship to Youth

\_\_\_\_\_  
Youth Signature Date

\_\_\_\_\_  
Youth Pride Staff Member/Clinician’s Name (please print) Signature Date

Name Used: _____	<b>OFFICE USE ONLY</b> Pronouns Used: _____
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