Jamie Smith Counseling, LLC

horizontal line

2103 E Washington St Bldg 3

Bloomington, IL 61701

ph.(309)-300-3072 fax.(309)365-6350

[jamiesmithcounseling@gmail.com](mailto:jamiesmithcounseling@gmail.com) [www.therapyinillinois.com](http://www.therapyinillinois.com)

MINOR ASSENT TO TREATMENT FORM

Minor therapy client: Therapy is a great way to work on problems/concerns relevant to you and your parents/caretakers. Part of successful treatment includes being open and honest with your therapist, and trying out the things we talk about in treatment in your daily life. Your therapist will make every effort to be clear about your privacy. Typically, your therapist will share general information with your parents/caretakers, such as whether you attended sessions and if you appear to be participating in treatment. Unless one of the situations your therapist discussed with your comes up (issues of child abuse, wanting to hurt yourself or others, or very risky behavior), your therapist will keep the specifics of therapy private. Sometimes you and your therapist may agree to involve your parents/caretakers in treatment, or to consult with them to get more information.

#### **Disclosure of records to parents of children age 12 to 18**

A parent or legal guardian of a recipient of services who is over 12 but under age 18 may always have access to certain kinds of records. Those are records about the child's current condition, diagnosis, treatment and medications being provided, and treatment and services needed.

The parent or guardian may have access to other kinds of mental health or developmental disabilities service records if the child does not object or if the therapist does not feel that there are strong reasons to [deny](https://www.illinoislegalaid.org/lexicon/176/letter_d#Deny) you access to the records. If the therapist or child denies access to those records, the parent or guardian may file a court action to seek access.

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: Initial the points below and include your signature at the bottom to indicate your agreement to respect your child’s privacy:

\_\_\_\_ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

\_\_\_\_ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s treatment.

\_\_\_\_ I understand that I will be informed about situations that could seriously endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_\_/\_\_\_

Parent Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_\_/\_\_\_

Parent Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_