



Informed Consent for Parents/Legal Guardians of Minors

During behavioral health services with your child, I may meet with parents/custodians/guardians, either separately or together. Please be aware, however, that at all times, my client is your child – not the parents/custodians/guardians, any siblings, or family of the child. If I meet with you or any other family members during your child's treatment, I will make note of that meeting in the child's treatment records. Please be aware that these notes will be available to any person or entity that has legal access to your child's treatment record and your information may not be protected, since the child is the only client and generally this information is available to both parents or legal guardians.

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have you or your child's permission. Examples of these situations may include, but are not limited to, the list below.

Confidentiality cannot be maintained when:

- Patients tell me they have plans to harm themselves or others and I believe they have the intent and ability to carry out this threat. I must take steps to inform a parent/custodian/guardian of what the child has told me and how serious I believe the threat to be, possibly law enforcement and/or the potential victims.
- Patients tell me they are doing things that could cause serious harm to themselves or others, even if they are not intending to cause harm. In these situations, I will use professional judgment to decide whether or not a parent/custodian/guardian needs to be informed.
- Patients tell me, or I otherwise learn or suspect, that a child is being neglected or abused (physically, sexually, mentally, or emotionally). In this situation I am required by law to report the alleged abuse to the appropriate state child protective services agency. This might include if a minor tells me they are sexting or viewing or circulating child porn.
- I am ordered by a court to disclose information. Therapy is most effective when a trusting relationship exists between the behavioral health provider and the client. Privacy is especially important in earning and keeping that trust, which is why it is important for minors to have a space of privacy, where they can discuss personal issues without fear that their emotions, feelings, and thoughts will be immediately communicated to their parents/custodians/guardians or other third parties.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information that your child has disclosed to me without your child's agreement, in most instances. This includes activities and behaviors that you may not approve of or may be upset by, but that do not put your child at risk of serious



harm. If your child's behaviors or activities become riskier or more serious, then I will use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that they are in such danger, I will communicate this information to you and potential to the proper authorities.

There may be other situations in which subjects arise that I feel would be beneficial for you to know, but it is not my place to share that information. In situations like these, I will work with your child and encourage them to tell you, helping them find the best way to do so.

Although Ohio law gives parents/custodians/guardians the right to see any written records that I keep about your child's treatment, unless blocked by court order, by signing this agreement, you are agreeing that your child should have a zone of privacy in their meetings with me and you agree not to request access to your child's written treatment records.

I understand that behavioral health services may include, but are not limited to, discussions on family history, educational achievements and aspirations, criminal history, and any medical/drug/drug-treatment history. Services may also include, but are not limited to: intake; diagnostic assessment; screening for other co-occurring diagnoses, physical, sexual, mental, and emotional traumas; group therapy options; and family therapy options. I understand that my child's provider will review my child's symptoms and behaviors in order to diagnose (or rule out diagnoses) for my child based solely on evidence, even if it is a diagnosis that I may disagree with. I give consent for my child's provider to diagnose or treat my child as you deem it appropriate. Examples of diagnoses that I consent to, as long as they are applicable to my child, with resulting treatment include, but are not limited to: depression, anxiety, attention-deficit hyperactivity disorder, obsessive compulsive disorder, gender dysphoria, gender-related condition, post-traumatic stress disorder, autism spectrum disorder, eating disorders, oppositional defiant disorder, bipolar disorder, and/or personality disorders.

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided periodic updates about general progress and/or may be asked to participate in therapy sessions as needed. Although I may have the legal right to request written records or 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, although I understand that I may revoke this consent in the future.

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted.

By signing, you show that you have read and understand the policies described. If you have any questions as we progress with therapy, you can ask me at any time.



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Name of Minor: _____

Birth Date of Minor: _____

Parent/Guardian Signature: _____

Date: _____

Clinician Signature: _____