INFORMED CONSENT (CHILD AND ADOLESCENT) CONFIDENTIALITY: TOUCHSTONE LIFE CENTER (TLC)

Clients are often unsure what to expect from their first visit or consultation with a Behavioral Health Provider. We encourage you to consider the following points regarding your care, and to discuss them with your Provider if you wish. You can expect the attention, respect and best professional efforts of your Provider. Your Provider will treat you as a responsible individual and will expect you to take an active part in your treatment. You should also expect to take part in the treatment decisions. You should understand the goals and direction treatment is taking, and if you do not understand, you should ask. Before initiating a professional evaluation or treatment relationship with a Provider, we want you to know about privacy ground rules.

Generally, information discussed during your evaluation and treatment sessions is confidential and may not be released to anyone outside of the offices of TLC without your permission. In other words, in most circumstances, a release of your medical information requires your consent. However, under some limited circumstances, your information may be released without your permission. Your Provider will review these possible circumstances with you, but please notify us if you have any immediate concerns.

Children and adolescents 13 and older.

Children age 13 and older have the right to consent to mental health treatment without parental consent. A client's consent may be necessary before we can lawfully divulge information pursuant to a parental request. It is this provider's approach that for dependent children in order to have a prescription medication a parent must be informed of what medication is being prescribed, its risks, benefits and interactions with other medications to be able to support their child in regards to better mental health. There may be exceptions to this but it is my standard of practice.

Your Care is Documented in your Providers Electronic Medical Record and paper chart maintained at the offices of TLC.

Your mental health care team may have access to your medical record to ensure consistent, quality care. Additionally, TLC authorized personnel, may have access to your medical record for quality assurance reviews. We may also share information with other medical providers and case managers for the purpose of treatment planning and coordination of care.

Child, Spouse or Elder Maltreatment.

Providers must report suspected child abuse or neglect, and other incidents of family maltreatment to appropriate agencies such as local child protective services and authorities, or both.

Crimes or Fraud.

Providers must report any threat to commit crimes or fraud or any serious intentions to violate the law.

Danger to Self or Others.

Providers must take steps to protect individuals from harm when the client presents a serious threat to the life or safety or self or others.

Information Provided in Our Electronic Paperwork System.

This information may be used for medical research purpose without disclosure of any of your personal identifiers.

Legal Actions/Proceedings.

If you are involved in legal actions/proceedings, your medical records may be subject to subpoena or lawful directive from a court. Release is coordinated with legal consultation to ensure only relevant information is released.

Washington State Law requires that we obtain a signed office policy agreement from the custodial parent of guardian before rendering psychological/psychiatric services to a child or adolescent. I have read the above and understand that my medical information will be safeguarded within the above described limits and in accordance with the Privacy Act of 1974

_____	_____	_____
PARENT NAME (PRINT)	PARENT SIGNATURE	DATE
_____	_____	_____
ADOLESCENT NAME (AGE 13 AND OLDER) (PRINT)	ADOLESCENT SIGNATURE	DATE

I have inquired to ensure the client understood the above description of the Limits of Privacy.

__Kris A. Peterson MD_____	_____	_____
HEALTH CARE PROVIDER NAME (PRINT)	HEALTH CARE PROVIDER SIGNATURE	DATE

_____	_____	_____	_____
CLIENT NAME (PRINT)	**DOB**		**SSN**