Laurie J. Hall, LCSW
Psychotherapist
1545 Hotel Circle South., Suite 250
San Diego, CA 92108
(619) 297-0025 / Fax (619) 996-2152

Consent For Treatment

Primary Client: _____ D.O.B._____

I _____, hereby authorize Laurie J. Hall, Licensed Clinical Social Worker, to provide psychotherapeutic services to my child or myself. I understand that therapy is voluntary and that I have the right to receive and refuse services. I am aware that I may end my service at any time for any reason, even if my therapist may feel it is inadvisable. I understand that if I choose not to return that I will attempt to inform my therapist about my choice. I am also aware that I have the right to receive respectful service and to be informed about all aspects of my treatment. I realize that although therapy may be helpful, that there are no guarantees that any or all of my problems will be remedied. I understand that service will be terminated when my goals have been met.

Confidentiality

The information you share with me is one of the most important things to understand. Ordinarily, anything and everything that is shared with me is maintained confidential. However, there are four circumstances in which I would be required by law to reveal information without your consent:

1) If you are in serious danger of harming yourself.
2) If you are in serious risk of harming another person.
3) If there is a minor, an elderly person, or a disabled person in care, who is at risk or is being abused either physically, sexually, emotionally, and/or is being neglected.
4) If there is a court order compelling me to release your clinical record to a court of law.

If for some reason we decide that in your interests I should provide some part of your confidential information to another professional, your insurance company, your attorney, social worker, or collaborating agency, you will sign a time limited release of information detailing the information and purpose of the disclosure.

By signing below I acknowledge the above office policies and procedures consent to be treated for psychotherapy by Laurie Hall, LCSW, and understand that I have been informed of what constitutes confidentiality.

_____ _____
Clients Signature/Parent/Legal Guardian Date

_____ _____
Laurie J. Hall, LCSW Date