Peace Purpose

Positivity Power

Acknowledgement of Confidentiality of Records for Adolescent Clients

I/we have been informed that adolescents (children 12 through 17) have confidentiality rights regarding their therapy records and information disclosed in therapy.

We understand that an adolescent child has the right to keep confidential information s/he shares with his/her therapist and that the therapist is bound to keep this information confidential and cannot release information disclosed in treatment unless the adolescent consents to its release.
A release is required for releasing this information to parents!
We have been informed that parents of an adolescent client are entitled to a summary of treatment: dates seen, general focus of therapy and goals.
We have been informed that confidentiality can and will be broken in the following conditions:
a. Court orders for clinical records
b. Suspicion of child abuse
c. Imminent risk of harm to self or others *
*(this refers to suicidal behavior and threats to kill one self or severely injure or kill others)

We have been informed that as a result of the confidentiality privilege the therapists of adolescent children are required to keep confidential information about problematic behavior if it does not meet the criteria stipulated above. We understand that Patrick McKee, LCPC will do his best to guide adolescent clients and help them avoid and/or stop problematic behavior.
Please note that confidentiality covers past high-risk behaviors. Therapists cannot disclose instances of past high-risk behavior if the adolescent client is clear and credible that s/he is no longer engaging in such behavior.
Please note that Patrick McKee, LCPC will strive to help adolescent clients stop problematic, dangerous and destructive behaviors. We seek to involve parents in the therapy process in order to improve parent-child communication and help parents find ways to assist their adolescent children in stopping negative behaviors. Thus, we always raise with adolescents the importance of sharing their concerns and difficulties with their parents.

P4 Counseling & Wellness Center, LLC Acknowledgement of Confidentiality of Adolescent Treatment Records

I/We _____ (names of parents)
and I _____ (name of adolescent client) acknowledge that we have read, received a copy of, and understand P4 Counseling & Wellness Center, LLC's Policy regarding Confidentiality of Adolescent Treatment Records/Information.
Signature of client: _____ Date:_____
Signature of parent/guardian: _____ Date:_____
Signature of parent/guardian: _____ Date:_____
Witnessed by: _____ Date: _____

401 E. Prospect Ave, Suite 208; Mount Prospect, IL 60056 Phone: 847-922-5278 Email: patrickmckeelcpc@gmail.com www.patrickmckeelcpc.com