don't grow up invisible
Youth Pride Inc.

AGES 14-17 *(Use if 18 & in Social Service System)

Guardian Consent Form

As the legal guardian of_____, (date of birth__/___/___), *I am authorized to act on behalf in making health care decisions.*

I understand that various types of services are provided by Youth Pride Inc. staff, clinicians, interns, and/or volunteers. These services include but are not limited to individual psychotherapy, group support, and case management services. I understand that these services are available for free.

I have the right to revoke this authorization at any time. This authorization is valid until services are terminated, or until __/___/___

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone outside Youth Pride Inc. without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled, or when a client's family members communicate to Youth Pride Inc. that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If your mental status is at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Youth Pride Inc. Staff at Youth Pride Inc. will use their clinical judgment when revealing such information. Youth Pride Inc. will not release records to any outside party unless you authorize us to do so.

EMERGENCY: If there is an emergency or when Youth Pride Inc. becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, Youth Pride Inc. staff and clinicians will do whatever they can within the limits of the law, to prevent you from injuring yourself or others, and to ensure that you receive the proper medical care.

CONSULTATION AND SUPERVISION: Youth Pride Inc. consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained Unlicensed Youth Pride Inc. clinicians will be supervised by a licensed clinical supervisor and your information may be discussed confidentially in supervision.

RECORDS: Both the law and the standards of the clinical profession require that Youth Pride Inc. keep treatment records for clients. If you have concerns regarding the treatment records, please discuss them with Youth Pride Inc. staff. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Youth Pride Inc. assesses that releasing such information might be harmful in any way.

COURSE OF THERAPY: While you can expect benefits from psychotherapy, you fully understand that no particular outcome can be guaranteed. You understand that you are free to discontinue treatment at any time but that it would be

best to discuss with the psychotherapist any plans to end therapy before doing so.

CONTACTING THERAPIST: If you need to reach your clinician outside of the clinician' s weekly hours, please contact a Youth Pride Inc. staff member and they will contact your clinician for you. If an emergency situation arises and you may not feel that you are safe, please call 911 or go to the nearest emergency room .

SOCIAL NETWORKING AND INTERNET SEARCHES: Youth Pride Inc. Clinicians do not accept friend requests from clients on social networking sites, such as Facebook/Snap-Chat/Instagram or Twitter. Communicating via such sites can compromise client's privacy and confidentiality. For this same reason we request that clients of YPI do not communicate via any interactive or social networking websites with staff, interns or volunteers.

I **have read the above information.** I **understand them and provide consent to participate in and receive individual psychotherapy, group support, case management, and other services at Youth Pride Inc**.

Client Name (please print) Signature Date

Address

Home Phone Cell Phone Work Phone

Youth Pride Staff Member/Clinician's Name (please print) Signature

Office Use Only: Pronouns Used:_____ Birth Name_____

Name Used: _ _ _ _ _ _ _ _ _ _ _ _ _

OFFICE USE ONLY

Pronouns Used: _ _ _ _ _ _ _ _ _ _ _ _

Updated 09.10.15