not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual discussion may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Policy for Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy however, to treat individuals between the ages of 14 and 17 more or less as adults. To that end I request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will do my best to discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Please bring any questions or concerns you may have about this document to our next meeting. We can discuss any questions you have about the policies at that time.

When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

Patient Name: _____

Full Address:

_____

Phone: cell: _____ Phone home: _____

Email: _____ Birth Date:_____

Emergency Contact:

_____

Patient Signature: _____ Date: _____