ADOLESCENT CONSENT FORM

Teen Name: ______________________________ Date of Birth: ______________________

Address: ________________________________ City: _____________ Zip code: ________

Parent/Guardian:___________________________

Phone Number: ___________________________

Safe to leave message? No___ Yes, leave caller name and # only___ Yes, no restrictions___

Confidentiality:

We protect the privacy and confidentiality of all adolescent clients receiving services. The therapist will not tell any person, *including parent(s)/legal guardian(s)*, what is discussed during therapy sessions unless required to do so by law. Confidentiality may be broken in the following situations:

(a) Concerns about child abuse/neglect.
(b) When there is concern that the teen may hurt themselves or someone else.
(c) When ordered by a court of law.
(d) Discussions with other Safe Connections professionals or auditors.

Adolescent Client and Parent/Legal Guardian's Rights:

All Safe Connections services are voluntary. If a client and/or the parent(s)/guardian(s) of a client feel as though they have been mistreated in any way, they have the right to file a grievance with the Assistant Director for Clinical Services regarding their treatment.

Parent/Guardian Permission for Services:

I understand the terms of confidentiality and my rights as a parent/guardian

I give permission for the minor to receive services from Safe Connections.

I give permission for my child to receive (please check): ☐ support groups ☐ individual therapy

______________________	______________________	__________
Parent/Guardian name printed	**Parent/Guardian Signature**	**Date**
______________________	______________________	__________
Therapist name printed	**Therapist Signature**	**Date**

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safeconnections.org • 24-hour Crisis Helpline 314-531-2003