Whitten Psychological Services

Informed Consent to Treatment and Limits of Confidentiality

Services are provided within the Whitten Psychological Services by clinicians licensed by the Commonwealth of Kentucky. Your service provider should accomplish the following: 1) identify his or her professional status 2) clarify with you the nature and course of treatment or assessment, and discuss any concerns or questions you may have regarding your care, and 3) obtain your consent to treatment or assessment.

All service providers within the Whitten Psychological Services insure the confidentiality of the information disclosed by their clients within the limits described below. In most cases, when client/patient information needs to be disclosed, the client's permission is obtained before disclosure. There are, however, circumstances when disclosure can occur without the client's prior consent. These include disclosure as permitted by the Federal Privacy Act, by law, by judicial proceedings, by Medical Quality Assurance review and by standards of ethical professional practice. The following are typical but not exhaustive examples of situations and circumstances under which information may be disclosed without prior consent.

1. If a provider believes you intend to harm yourself or someone else, it may be the duty of that provider to disclose that information for protection of the endangered person(s).
2. In situations of suspected child, spouse, or elder abuse, it is the duty of the provider to notify medical, legal, or other authorities.
3. If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
4. Qualified persons may be permitted access to your record as part of professional quality assurance review procedures. Any information disclosed by the reviewer conceals the identity of the patient.

Statement of Understanding: I have read the above and understand the nature of the service providers and the limits of confidentiality outlines above. I consent to treatment or assessment and understand that II may voluntarily withdraw from treatment or assessment at any time.

______________________________ ________

Client/Patient Signature Date

______________________________ ________

Parent/Guardian Signature Date

Health Service Provider's Statement: I have inquired to insure that the client/patient understood the above description on the limits of confidentiality and provided informed consent to treatment.

______________________________ ________

Clinician Signature Date