The Actors Fund
Looking Ahead Program

CONSENT FOR TREATMENT OF MINOR

I/We, _____ give my/our consent to The Actors Fund's Looking Ahead Program to conduct counseling/psychotherapy with the minor client, _____

My/our relationship to the minor client is _____

I/we were notified that the holder of the psychotherapist-patient privilege is _____
(name of minor client)

Because counseling is based on a trusting relationship between counselor and client, the counselor will keep information shared by the client confidential except in certain situations in which an ethical responsibility limits confidentiality. You will be notified under the following circumstances:

1. The student reveals information about hurting himself/herself or another person.

2. The student or another person may be in physical danger.

3. If there is belief that there is some kind of physical and or sexual abuse

I/we were also notified that all material discussed during the counseling/psychotherapy sessions is generally confidential unless disclosure of such information is demanded or permitted by law, as explained in the social services-informed consent form that I/we have read and signed.

I/we were also notified that the minor client may have the right to authorize the release of confidential information, especially if the minor client did or could have consented to counseling/psychotherapy her/himself.

I/we were also notified that the counselor has the right to withhold confidential information from me/us if 1) the minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the counselor's professional relationship with the minor client, or 2) the minor client's counselor determines that sharing confidential information with me/us would have a detrimental effect on the minor client's psychological safety or well-being.

I/we understand that The Actors Funds Looking Ahead Program will exercise clinical judgment in disclosing any information derived in the confidential relationship with the minor client that indicates that the well-being of the minor may be in danger or jeopardy. I will accept The Actors

Funds Looking Ahead Programs judgment in releasing and sharing such information obtained during the course of counseling/psychotherapy.

Name_____Relationship_____

Signature_____Date_____

Name_____Relationship_____

Signature_____Date_____

If the person(s) signing this consent is/are either (1) the parent of the child and legally separated or divorced from the child's other parent, or (2) not the parent(s) of the child, please attach a copy of the document, or portion thereof, which authorizes you to make healthcare decisions for the child.

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