



Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so.

We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with. Your child may be too scared, angry, or ashamed right now to share those issues with you.

We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to Colorado law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

You should know that this confidentiality has limits. If there is any threat to your child's safety or his/her life, we have the duty to inform you and help to create a plan for safety.

In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include:

- threats against another person
- physical or sexual abuse
- neglect
- pregnant women who report using drugs

Finally, we recognize how challenging it can be for a parent to raise a child. We know how badly you might want to know everything your child discloses in counseling. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

Consent to Counseling

I, _____, give consent to have my daughter/son
(name of parent or guardian)

_____ enter into counseling with
(name of client)

_____ at Kindred Counseling, PLLC.
(name of counselor)

I understand that the communication between _____
(name of client)
and her/his counselor is confidential, and that confidentiality will be broken only in the case of her/his being a danger to herself/himself or to others, or if she/her is involved in illegal activity, or if otherwise required by law. Therefore, I fully understand that even I as parent will not be provided with any information regarding communication between my child and his/her counselor. I have had the opportunity to fully discuss with said counselor the risks and benefits of treatment, as well as treatment choices and methods. I have had all my questions answered and I understand and approve the treatment that is planned.

Under penalty of law, I hereby declare that I am the parent of this child. Parent means a biological or adoptive parent having legal custody of the child or a person or agency judicially appointed as legal guardian of the child.

Dated this _____ day of _____, _____.

Signature of Parent or Guardian: _____

Signature of Parent or Guardian: _____