Acct # _____

Scan Date _____

MASTERPEACE

Center for Counseling and Development

CONFIDENTIALITY CONSENT - COORDINATION OF CARE

CONFIDENTIALITY STATEMENT

As professionals, we maintain and safeguard the confidential nature of the information obtained within the treatment or testing relationship. All records, communications, treatment, and testing information pertaining to each client will be treated as private and confidential matters as governed by Section 748 of the State of Michigan Mental Health Code, Act 25. However, MASTERPEACE will communicate information that would otherwise be confidential under the following circumstances: (**these are EXCEPTIONS to the general policy of confidentiality)**

1. Client has given MASTERPEACE written permission to discuss his/her case with another person or agency.
2. MASTERPEACE becomes aware of serious threats (suicidal or homicidal) to the personal safety of someone.
3. MASTERPEACE receives information indicating, suspecting, or substantiating (sexual or physical) abuse, neglect, or exploitation of a child, aged adult, or persons vulnerable as a result of mental disability or functional illiteracy.
4. MASTERPEACE is ordered to do so by a court of law.
5. When necessary for periodic case review with other MASTERPEACE staff for purposes of supervision and consultation.

RECEIPT OF NOTICE OF PRIVACY POLICY

My signature below also indicates I have received a copy of MASTERPEACE Center for Counseling & Development's Notice of Privacy Practices.

CONSENT FOR TREATMENT OR TESTING

I give MASTERPEACE permission to provide treatment or testing to myself and/or other individuals deemed necessary for my mental health care. I understand that my participation at MASTERPEACE is voluntary and that this Consent for Treatment or Testing will remain in effect for the duration of this treatment or testing period unless I revoke my consent in writing. In addition, I understand that the treatment outcome is different for each individual and cannot be guaranteed.

I, the undersigned have the legal authority to consent to treatment, without the added consent of any additional individuals. I have read the above statements and discussed it with my therapist who has fully answered any of my questions regarding Notice of Privacy Policy, Confidentiality, and Consent for Treatment or Testing as recommended by MASTERPEACE.

IF THE CLIENT IS A MINOR

The person signing below has legal authority to Consent for Treatment or Testing and will inform MASTERPEACE immediately if that authority changes. If the person signing below has joint legal custody of the client, you are responsible to inform the person who shares joint legal custody that the client is being seen by a therapist at MASTERPEACE.

_____ _____

Signature *(Parent/Guardian must sign if client is under 18 years old)* Date

_____ _____

Print Client's Name Print Parent/Guardian Name (if minor)

COMPLETE BELOW if you request Masterpeace to notify your physician of your sessions.

Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____