# Horn and Associates in Rehabilitation, PLLC

## CONSENT AND PERMISSION FOR SERVICES AND/OR TREATMENT

I understand that Horn and Associates in Rehabilitation, PLLC is providing mental health assessment and treatment services to me. I understand that there are no certain outcomes from these services and that individual experiences with treatment may vary. In giving consent to provide these services to me, I am aware that Horn and Associates in Rehabilitation, PLLC has a duty to protect my confidentiality except where law requires disclosure of certain information. There are several exceptions in which confidentiality cannot be assured.

Duties to report include:

- A duty to report the abuse or neglect of a dependent adult and/or domestic violence offenses to the Department of Community Based Services
- A duty to report any instances of child neglect, exploitation, or abuse to the Department of Community Based Services and/or the police
- A duty to report any threats against persons to the intended victim and the police
- A duty to release information to agencies or persons with a need to know when a client is in need of hospitalization

When a client introduces personal mental health or substance abuse issues in court proceedings, confidentiality is then waived by the client.

Understanding all of the above possible exceptions of confidentiality regarding information about my mental health condition and treatment, I give consent to Horn and Associates in Rehabilitation, PLLC and its clinicians to provide assessment and treatment services to me.

I also give consent to release any applicable mental health information to my Primary Care Physician. This release pertains to information about my appointments, diagnoses, treatment recommendations, and medications prescribed; it is for the purpose of assisting in coordinating my care. I may revoke this consent at any time I choose except to the extent that action has to be taken on reliance upon it.

Name and Address of Primary Care Physician (note if no PCP designated):

_____

_____

Please check and initial all that apply:

_____ *Release any applicable mental health information to my PCP named above*

_____ *Release any applicable medical health history information to my PCP named above*

_____ *Do NOT release any information to my PCP named above*

Client Name (print): _____ SSN:_____

Client Signature:_____ Date:_____

Name of Guardian, if applicable (print):_____

Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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