

**WORCESTER YOUTH & FAMILY COUNSELING SERVICES, INC.**

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_ acknowledge that I have read and understand all of the information described in the corresponding packet. I have thoroughly read the confidentiality statement and understand that there are specific exceptions in which confidentiality will be broken.

These exceptions are:

1. A risk of imminent danger to myself or to another person.
2. Suspicion that a child or elder is being physically abused, sexually abused or neglected.
3. When there is a valid court order issued for medical records.

I authorize Worcester Youth and Family Counseling Services, Inc. to provide adequate care for my mental health needs. I understand that I may withdraw this consent in writing and terminate treatment at any time.

Client Name (please print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

If applicable:

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_