NORTHWEST MICHIGAN
HEALTH SERVICES INC

Adolescent Informed Consent Form

Information you share in therapy sessions is confidential, unless you give consent to disclose certain information. However, there are exceptions to this rule that are important to understand prior to starting with the therapy process. In some situations, it is required by law or professional guidelines that information discussed in therapy must be disclosed. Some of those situations are described below. Most involve your protection and the protection of others from the potential to be hurt or harmed.

Please check each box after you have read each section:

- ☐ I understand that if I am 17 years old or younger and I understand my actions, I can receive help for counseling.
- ☐ I understand that I have the right to deny or refuse services.
- ☐ I understand that I am freely choosing to enter into Northwest Michigan Health Services School Based Behavioral Health Service, and I understand that I may discontinue treatment at any time.
- ☐ I understand that my behavioral health provider may not tell my parent or guardian or others about my treatment unless I give permission. However, my behavioral health provider may tell my parent or guardian or other necessary authorities if:
  - I may harm myself
  - I threaten to hurt someone else, and my behavioral health provider believes I will act on that threat
  - I am being harmed by someone else
- ☐ I understand that I do not need permission from my parent or guardian for the service listed above and the Behavioral Health Specialist does not need permission from my parent or guardian to provide the service listed above.
- ☐ I understand that if I am 14 years or older, I can only receive limited outpatient mental health (counseling) services for 12 visits or 4 consecutive months without permission from my parent or guardian.

Notice of Privacy Practices Acknowledgement

- ☐ I understand that Northwest Michigan Health Services School Behavioral Health program, is in compliance with all Health Insurance Portability and Accountability Act (HIPAA) law and regulations. The full privacy statement is available to review.

_____	_____	_____
Printed Name of Student	Signature of Student	Date

I have discussed all the above information with the student. I have answered all his/her/their questions and satisfied that he/she/they understand all the information.

_____	_____	_____
Printed Name of Witness	Signature of Witness	Date