Melvin L. Cauthen, LICSW, LCSW-C

Motivating Life Changes

1623 K Street, NW

Washington, DC 20009

202-555-5555

**INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that as a subscriber to the University of Rochester Student Health Program I am eligible to receive a range of services at University Counseling Center (UCC). The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is

provided over the course of several weeks.

I understand that all information shared with the clinicians at UCC is confidential and no information will be released without my consent. During the course of treatment at UCC, it may be necessary for my therapist to communicate with providers at the University Health Service (UHS). While written authorization will not be requested, prior to any discussion with UHS providers, I understand that my therapist will discuss UHS communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides UCC services. All professionals-in-training are supervised by licensed staff. See reverse page for a listing of all UCC supervisors.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that UCC routinely videotapes therapy sessions. I understand that such recording(s) will be used only for educational purposes and that the professionals involved will respect and protect the confidential nature of the sessions. I understand that the tapes will be the property of the University Counseling Center. I also understand that if I object to be videotaped, it will in no way jeopardize my relationship with the University Counseling Center.

If I have any questions regarding this consent form or about the services offered at UCC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by UCC. I understand that I may stop treatment at any time.

**Please see other side of this form if referred by a Member of the Uof R Faculty/Staff.**

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Signature Date