UNIVERSITY OF ROCHESTER - UHS **CONFIDENTIAL**
UNIVERSITY COUNSELING CENTER

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.

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.

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.

_____________________________________ ___________________________
Signature Date

This Box is For Use ONLY If You Were Referred by a Member of the Uof R Faculty/Staff:
May we notify the person who referred you to Counseling Services that you followed through with the referral? If so, sign below to grant us permission to inform this person that you attended an initial appointment at Counseling Services. *Please note the following*: 1) you may choose *not* to sign and this will in no way influence any treatment which you might receive here, and 2) other than a letter confirming that you attended an initial appointment, **no** additional information will be shared without your consent. **Complete the area below ONLY if you agree to provide us with consent to inform the faculty/staff member who referred you; be sure to both fill in the contact information and to sign your name.**

Name of Faculty/Staff Member: ____
Department:_________________________________ Phones Number ___________________
I have read the above and agree to release this information to the person named here.
______ **YES** Your Signature: ____