

**Counseling & Health Center**

317 West "F" Street Ontario, CA 91762  
Phone: (909) 391-3051 / Direct: (714) 325-5621 / Fax: (909) 391-3068

**Mental Health Disclosure Form**

**Treatment Philosophy – Explanation of Brief Therapy**

Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

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**Limits of Confidentially Statement**

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patients presents as a physical danger to self (Johnson v county of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect are suspected (Welfare & Institution and/or Penal Code).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion is not to be discussed outside of the counseling sessions.

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**Release of Information**

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

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**Emergency Access**

Practitioners are available after hours to handle emergencies. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner.

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**Consent for Treatment**

I authorize and request my practitioner carry out psychological exams, treatment and / or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

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**Patient / Guardian Signature**

**Date**

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**General Consent for Child or Dependent Treatment**

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

**First Name**

**Middle Name / MI**

**Last Name**

**Social Security Number**

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**Signature of Legal Guardian / Legal Representative**

**Date**

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