TeleHealth Counseling

Yvonne Sinclair M.A., LMFT #MFC35807

916-434-2877

**PSYCHOTHERAPY TREATMENT AUTHORIZATION**

Authorization is hereby given for psychotherapy treatment for my minor child

Child’s Name

\*I understand everything said in session is confidential by California law. Parents are also excluded in this confidentiality law. If information is given parents should know, the therapist and the client will work out how to tell the parent.

\*I understand there are exceptions to this law as follows;

If child abuse is suspected

If elder abuse is mentioned

If client is in danger of harming self, others, or others property

If client is unable to care for self (if a minor, minor is living independently)

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Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Date

\*I understand I must sign an authorization for exchange of ANY information, so the therapist may communicate with individuals outside of this office. Those “others” may include teachers, doctors, previous therapists, and/or another parent or caregiver.

\*I understand this authorization can be changed and/or revoked in writing at any time.

**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

Authorization is hereby given for the exchange of relevant information regarding the above mentioned minor client between Yvonne Sinclair M.A., LMFT and ;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company to use

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Parent/Guardian Signature date

Fill out areas highlighted in Yellow, cop/paste or scan and attach to an email to: yvonne@revitalize4life.com