



## INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and consent to psychological services by \_\_\_\_\_  
(BBHW Clinician)

This consent applies to myself, those under my legal guardianship or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion. I understand that all staff of Barrington Behavioral Health & Wellness (BBHW) may consult and collaborate on cases where therapeutically appropriate. I understand that all BBHW staff are bound to the same standards of confidentiality as indicated herein.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold \_\_\_\_\_ harmless for releasing information under the above conditions.  
(BBHW Clinician)

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_