William J. Kuzbyt, Psy.D., JD, CAP
Licensed Psychologist, PY6646

INFORMED CONSENT

Dr. William J. Kuzbyt avails therapy services to his patients. Consent to receive services is required of all patients prior to beginning treatment. Within the purview of all applicable laws, Dr. William J. Kuzbyt and staff will safeguard your confidentiality and your relationship with his services will not be revealed to anyone without your prior written consent. However, under certain conditions, the clinic is legally and ethically obligated to release information about a client whether or not the client approves. These conditions are:

1. Suspected abuse (physical, sexual, or neglect) of children, the aged, and the disabled: As counselors and psychologists, we are required by law to report suspected abuse to the Department of Health and Rehabilitative Services.

2. Potential to harm self or others: In instances where a client threatens to harm someone we may have to notify the intended victim and police. Likewise, if a client is thought to be at high risk for hurting him/herself, family and/or authorities may need to be notified in order to protect the client.

3. Court-order: We must release a client's records if a judge issues a court order compelling us to do so.

You should withhold your signature from this page until any difficulties, problems, or questions have been satisfactorily answered.

Your signature, giving consent to these procedures, is required in the appropriate section before we can provide services.

Adult Clients (18 years of age and older):

I, ______________________________ have read and understand the foregoing information concerning behavioral health
(client name)
services and by my signature do hereby give full and complete consent to receive services. I also understand the limits of confidentiality as specified above.

______________________________ __________
Client's signature Date

____
Witness

Child Clients (those under 18 years of age):

I, ______________________________ have read and understand the foregoing information concerning behavioral
(parent/guardian name)
health services and by signature do hereby give full and complete consent to allow treatment for my child ____________.
(child's name)
I also understand the limits of confidentiality as specified above.

_________________________ _______________________
Signature of parent or guardian Relation to minor child

_________________________ _____________
Witness Date