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www.thekerwingroup.com
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214-265-6051

CONSENT TO TREAT

I, _____, am the legal guardian or authorized representative for _____(child's name). I am requesting that Kerwin Testing and Therapy Group provide psychological services. I understand that records and information collected about a client will be held and released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that the treatment provider report all cases of abuse and neglect of minors or vulnerable adults. I understand that the clinician is also required by law to report all cases in which there exists a danger to self or others. I understand that there are circumstances in which the law requires the treatment provider to disclose confidential information. I consent to the provider communicating confidential information concerning the client to others in accordance with the law and reasonable professional judgment when such communication appears needed to protect others or the client from harm, in response to legal processes, or in other proper circumstances. Any further disclosure of information will be per my written consent, as the child's guardian or authorized representative. I understand that I may revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as required.

My signature below is to serve as consent to provide services as requested on the referral form. My signature also confirms that I have read and agree with the terms documented on the HIPAA and Professional Disclosure Statement forms.

_____ _____

Signature of Legal Guardian or Authorized Representative Date