Crawford Consulting and Mental Health Services, INC

"Healing Life through the Experience of Living"

I give consent for (myself or my child) to receive behavioral and/or mental health services from Crawford Consulting and Mental Health Services, INC. I have discussed with the mental health clinician the various aspects of psychotherapy assessment and diagnostic procedures, the methods of treatment available, and the applicable fees, and I have been given written information about these issues.

I understand that all records pertaining to these mental health services will be maintained in a secure and locked location. The limits of confidentiality related to these mental health services have been carefully explained and I fully understand that outside of certain narrow exceptions mandated by law and described above, these records are confidential and will not be shared with anyone inside or outside of the Crawford Consulting and Mental Health Services, INC without my expressed and/or written permission (either the parent/legal guardian or the client).

I have read the above information and give consent for mental health services to be provided to myself or my child.

_____ _____

Client Name (Printed) Date

_____ _____

Signature of Client or Legal Guardian if Minor Date

_____ _____

Witness Date

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