

# Horgan & Saling Counseling Services LLC

141 Wall St., Princeton, NJ 08540

609-580-1075

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## Informed Consent Regarding Limitations On Confidential Communications

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

1. IF NECESSARY TO PROTECT MY SAFETY OR THE SAFETY OF OTHERS.
  - (A) If I am clearly dangerous to myself my therapist may take steps to seek involuntary hospitalization and may also contact members of my family or others.
  - (B) If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may:
    - tell any reasonably identified victim;
    - notify the police; or
    - arrange for me to be hospitalized
2. IF NECESSARY FOR ME TO BE HOSPITALIZED FOR PSYCHIATRIC CARE.
3. IF A JUDGE THINKS THE THERAPIST HAS EVIDENCE ABOUT MY ABILITY TO PROVIDE CARE OR CUSTODY IN A CHILD CUSTODY OR ADOPTION CASE.
4. IN COURT PROCEEDINGS INVOLVING THE CARE AND PROTECTION OF CHILDREN OR TO DISPENSE WITH THE NEED FOR PARENTAL CONSENT TO ADOPTION.
5. IF THE THERAPIST BELIEVES A CHILD, A DISABLED PERSON, OR AN ELDERLY PERSON IN MY CARE IS SUFFERING ABUSE OR NEGLECT.
6. TO PROVIDE INFORMATION REGARDING MY DIAGNOSIS, PROGNOSIS AND COURSE OF TREATMENT, OR FOR PURPOSES OF UTILIZATION REVIEW OR QUALITY ASSURANCE, TO A THIRD PARTY PAYOR.
7. IN A LEGAL PROCEEDING WHERE I INTRODUCE MY MENTAL OR EMOTIONAL CONDITION.
8. IF I BRING AN ACTION AGAINST THE THERAPIST AND DISCLOSURE IS NECESSARY OR RELEVANT TO A DEFENSE.
9. IF NECESSARY TO USE A COLLECTION AGENCY OR OTHER PROCESS TO COLLECT AMOUNTS I OWE FOR SERVICES.
10. IF A COURT ORDERS ACCESS TO MY RECORDS IN A SEXUAL ASSAULT OR OTHER CRIMINAL CASE.

I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical services I receive.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date