STEPHEN A. GIUNTA, PH.D., LMHC, NCC, CCMHC
FORENSIC FAMILY COUNSELING
PARENTING AND DIVORCE SERVICES

CONSENT FOR TREATMENT, CONFIDENTIALITY & AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Before we begin our work, it is necessary for you to:
1. Give your consent for this initial interview/assessment and any subsequent services.
2. Have your rights of confidentiality explained to you.
3. Agree to authorize the release or exchange of certain information to those individuals and/or institutions involved with our activities.

Please read the following statement and sign your name below.

1. I, the undersigned, certify that I am making an application for evaluation and/or counseling by Dr. Giunta. I further state that my attendance is voluntary and that I am aware that the services are restricted to individual, couples and/or post-divorce family counseling. It is understood that the services are not designed to replace the services of a parenting coordinator or custody evaluator. It is further understood that the services may not be recorded without the written consent of all the participants.

2. The confidentiality of client records is protected by Federal and State laws and regulations. Information regarding a client's participation or any other identifying information will not be disclosed unless:
   a) The client consents in writing;
   b) The disclosure is allowed by the court or other government agencies;
   c) Child/Elderly Abuse or Neglect is reported/suspected;
   d) The client reports intent to harm their self or another;
   e) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation including approved peer and utilization reviews of client's records, and the sharing of verbal information with agencies with which Dr. Giunta has working agreements to insure continuity of care and/or provide emergency services.

3. I agree that the following information may be released by or exchanged with Dr. Giunta:

1st Receipt/Provider - (e.g., medical doctor, educator, counselor) ____
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Information - (e.g., records, reports, observations) ____
____

2nd Receipt/Provider - (e.g., medical doctor, educator, counselor) ____
____

Information - (e.g., records, reports, observations) ____
____

____ ____________
Client Signature Date

____
Printed client's name, age, and relationship to signature

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