School-Based Health Center
Consent for Mental Health Services

I, _____, agree to participate in counseling or psychotherapy services with the Provider or Mental Health Specialist who is providing my treatment. I understand that these services may take place in person or via telehealth.

I understand that, by Illinois law, I am permitted to have up to 8 sessions, each not more than 90 minutes long, without consent from my parent or guardian. After the initial 8 sessions, consent will be sought from my parent/guardian, unless the Provider or Mental Health Specialist determines that doing so would be detrimental to my well-being. If this is found to be the case, this determination will be reviewed every 60 days until counseling or psychotherapy ends or I reach age 17 (see 405 ILCS 5/3-550).

I understand my participation is voluntary and I may end my sessions at any time. My privacy and confidentiality will always be protected. All reasonable and appropriate measures will be made to eliminate all confidentiality risks.

I understand the services I receive are part of my medical record. I understand the Provider, or the Mental Health Specialist will have access to my relevant medical information including psychiatric and/or psychological information, alcohol, and/or drug use, and other health records. I understand this consent form will become part of my medical record.

This consent will remain valid and on file with SIHF Healthcare and the School-Based Program as long as I am enrolled in the school district. I understand that I may revoke this consent at any time.

I agree that the above information has been reviewed with me either by being read to me and/or I have reviewed by email or in person. I have had an opportunity to ask questions and my questions have been answered.

Name: (print) _____**DOB:** ____/____/____

Phone (____) _____

Address_____

Signature_____ **Date** _____/_____/_____

School's Name_____