

Marlene Kastrinos, Ph.D., L.C.S.W., SAP

Consent to Treatment and Confidentiality

This is to certify that I give permission to Marlene Kastrinos, Ph.D., L.C.S.W., S.A.P. to provide counseling and/or psychotherapeutic services to myself, _____ and/or my child: _____.

I have been informed of the following:

All communication between the client and the therapist is considered to be confidential. Only in the following cases will that confidentiality be broken:

Abuse of Children and Vulnerable Adults

- If the therapist suspects or knows about the abuse of a child or elderly person, Florida State Law **mandates** that this information be reported to the Abuse Registry.

Duty to Warn and Protect

- If an individual intends to kill or inflict serious harm on another person, the therapist is **required** to break confidentiality to warn the person who is identified as the intended victim, as well as the police or other authorities.
- If the client discloses or implies a plan for suicide, the therapist is **required** to notify legal authorities and make reasonable attempts to notify the family of the client.

Consultations

In order to enhance your treatment, the therapist may consult with other professionals, therapists, doctors, and nutritionists, etc.

Signature

Date

Signature

Date