Heather K. Mazarakos MSW LCSW
HKM Psychotherapy Associates LLC
161 Cook Hill Rd Wallingford CT 06492

CONSENT FOR TREATMENT

HKM PSYCHOTHERAPY ASSOCIATES LLC

161 Cook Hill Rd

Wallingford CT 06492

I, _____

agree to participate fully and cooperatively in the evaluation and/or treatment as indicated by the staff of HKM PSYCHOTHERAPY ASSOCIATES LLC

It is understood that HKM PSYCHOTHERAPY ASSOCIATES LLC will not release information about my condition or treatment unless it is so authorized by me with signed permission, or is warranted because of medical or psychiatric emergency. It is likewise understood that I will not disclose information about any client(s) I may come in contact with at HKM PSYCHOTHERAPY ASSOCIATES LLC, and that this confidentiality is binding, even after I have completed or left treatment at HKM PSYCHOTHERAPY ASSOCIATES LLC.

The staff at HKM PSYCHOTHERAPY ASSOCIATES LLC are mandated reporters and they are obligated under Connecticut General Statutes 17a-101 to report suspicion of abuse or neglect.

Should I choose to drop out of treatment at any time I may do so voluntarily, but it is understood that my clinical case record will remain confidential and the property of HKM PSYCHOTHERAPY ASSOCIATES LLC.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

_____ _____

Signature of Parent, Guardian or Authorized Representative Date