Jessica Davidson

Licensed Professional Counselor | Child & Adolescent Therapy

Confidentiality with Adolescents in Therapy
(16 years and older)

Adolescents who have reached the age of 16 are able to consent for their own therapy in the State of TN. When adolescents are involved in therapy, their parents often have an interest in being involved in the therapy process and want some level of disclosure from the counselor regarding their adolescents' progress in therapy. The success of any therapy is generally dependent on a trusting and confidential relationship between therapist and client. For this reason, I will keep all records private and will not disclose the content of therapy sessions to parents except in cases where the adolescent is believed to be in significant danger, has reported child abuse, or if there is a court order requiring me to release records.

I will encourage both the adolescent and the parents to participate in family therapy sessions as needed/as appropriate to help facilitate healthy communication about the ongoing issues discussed in therapy, but this has to be at the discretion of the adolescent receiving therapy. It is only when your adolescent feels that he or she can confide in me that I can be of the most help to him or her and your family. With the adolescents' permission, I can provide general summaries of the therapeutic direction we are taking in session and will try and facilitate the adolescent's involvement in that discussion. Please feel free to discuss this policy with me at any time.

125 Belle Forest Circle, Suite 206 | Nashville, TN 37221 | 615-669-6487

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Authorization to Counsel Minor Children
(16 years and older)

I, _____ give my permission to
(Name of Parent (s) or Guardian)

Jessica Davidson, LPC-MHSP to see my son/daughter,
(Therapist)

_____ for therapy
(Name of Minor Child)

with and/or without me being present in the same session. I understand that I am the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trusting relationship between the counselor and my child, I give the counselor permission to reveal or withhold information which, in his/her clinical judgment, is necessary to protect the therapeutic experience and clinical gains for my minor child. The only exception to this discretion would be in the case of:

_____.

By signing below, I acknowledge this policy and assert that by signing the Parent/guardian's signature section below that I am the person legally responsible for the adolescent for whom I am seeking services.

In cases of divorced parents: I acknowledge that I am the legal guardian and will provide a copy of the parenting plan to support the involvement of the guardians legally required to be involved in the counseling process.

_____ _____
Client's Signature Date

_____ _____
Parent/guardian's Signature Date

_____ _____
Therapist's Signature Date

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