EARLY CHILDHOOD Wellness place

PARENT/COLLATERAL DISCLOSURE FORM

1. As you know, I am providing services to your child, ___________________, and I am authorized to share information with you and to obtain information from you. You are a "collateral" in the treatment process.
2. I recognize that your role in your child's life is very valuable; however, you are **not** my client. While we operate from a family systems perspective at Early Childhood Wellness Place, our treatment plan and goals are focused on your child. You will receive parent-coaching, but not individual therapy.
3. If you would like to receive counseling from a mental health professional, please let me know, and I will refer you to a therapist.
4. Any treatment information which I share with you is confidential. You are encouraged **not** to share that information with anyone else.
5. Any information that you share with me will be confidential, as part of your child's treatment record, and I may share that information with my client, or his/her parent/guardian if it is deemed to be impacting his or her progress toward treatment goals.

I understand these disclosures and agree to comply with them.

____ ______________

Parent Date

____ ______________

Therapist Date