Barbara Witkow, MA, LMHC
Individual, Couples & Family Counselor

CONSENT TO TREATMENT

I, ____ do hereby request and consent to treatment by Barbara Witkow, M.A. I understand I will participate in developing a treatment plan and goals that best address my needs or situation.

Release of Information:
Information revealed by the client during therapy is confidential and will not be shared with any other person or agency without the written consent of the client. Exceptions to this rule are:

- Court ordered presentation of treatment records for litigation purposes.
- Suicidal statements, which shall be shared with family members and appropriate mental health professionals should hospitalization be required.
- Statements of intent to harm others, which will be reported to law enforcement personnel and to the potential victim.
- Evidence of child abuse (physical or sexual), which will be reported to CPS (Child Protection Services) per state law. There is no statute of limitations in Washington for reporting sexual abuse of a child.
- Periodic professional consultation and supervision.
- If the contract is for a couple or family therapy, I will honor individual confidentiality at the client's request. However, open discussion may be encouraged among the partners or family group.

I hereby certify that I have read, understand, and agree to abide by this Consent to Treatment, and that I have had the opportunity to ask questions concerning it before signing it.

Name: ____
(please print)

Signature: ____

Therapist Signature: ____

Date: ____