# Andrew B. Sears, MA, LPCC

## Consent for Treatment

I, ______________________________ give informed consent for treatment by Andrew B. Sears, MA, LPCC. I understand that all information shared with him is confidential, and cannot be released without my consent.

I further understand that there are specific and limited exceptions to this confidentiality which include the following:

1) When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

2) When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, the clinician is legally required to take steps to protect the elder or child, and to inform the proper authorities.

3) When a valid court order is issued for medical records, the clinician is bound by law to comply with such requests.

______________________________________________

Client/Guardian Signature | Date

______________________________________________

Witness Signature | Date

# Andrew B. Sears, MA, LPCC

## Authorization for Exchange of Information

In order to comply with patient privacy regulations, including the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations on patient privacy and confidentiality,

I ___________________________________ hereby authorize


Andrew B. Sears, MA, LPCC
870 High Street, Suite 12
Worthington, OH 43085
P/F: 614-842-2121
E: andrewbsears.malpcc@gmail.com


And:

___________________________________________________

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To exchange my personal health information.

______________________________________________________________

Client/Guardian Signature Date

______________________________________________________________

Witness Signature Date