



**University Parent Consultation and Child Evaluation Service (UPCCES)
School Mental Health Program**

CONSENT FOR CONFIDENTIAL MENTAL HEALTH SERVICES

I, _____ consent for my child,
(Parent or Guardian of Client)
_____, who was born on _____ to receive mental
(Child's Name) (Month, Day, Year)
health services at DuVal High School through the Counseling Center of the University of Maryland College Park.

1. I understand there are various services that may be provided, including screening, assessment, and counseling at the individual, group or family level.
2. I understand that all records pertaining to these mental health services will be maintained in a secure and locked location separate from the school's academic or administrative records.
3. I understand that outside of certain narrow exceptions mandated by law these records are confidential and will not be shared with anyone inside or outside of the school without the written permission of the parent/legal guardian or the child client.
4. I understand the limits of confidentiality, and that confidentiality may only be breached in instances of suspected dangerousness, abuse or neglect, or by court order.

I have read the above information and give consent for mental health services to be provided to my child.

Signature of Parent/Legal Guardian Date

Printed Name of Parent/Legal Guardian Date

Parent Contact Information:

Parent Address: _____

Phone #: Home _____ Work _____ Cell _____

Signature of Client Date

Signature of School-Based Clinician Date