

Shuck & Associates, PLLC

DUTY TO WARN

If the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I, _____, specifically consent for the
(Client Name)
therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following person(s):

Name

Telephone Number

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned therapist. I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge that I have been advised by the undersigned therapist of the potential re-disclosure of my protected health information by the authorized recipients and that it will no longer be protected by the Federal Privacy Rule. I further acknowledge that the treatment provided to me by the undersigned therapist was conditioned on my providing this authorization.

(Print)

(Sign)

(Date)