THE UNIVERSITY OF IOWA

COLLEGE OF
EDUCATION

The Connie Belin & Jacqueline N. Blank International Center for Gifted Education and Talent Development

Nurturing **Potential** | *Inspiring* **Excellence**

ASSESSMENT AND COUNSELING CLINIC

AUTHORIZATION TO PROVIDE ASSESSMENT SERVICES TO MINORS

I understand that my minor son or daughter has applied and been accepted for services at the Assessment and Counseling Clinic, The Connie Belin & Jacqueline N. Blank International Center for Gifted Education and Talent Development (Belin-Blank Center) contingent upon my authorization of the provision of such services. I hereby authorize the staff of the Assessment and Counseling Clinic to provide assessment services deemed appropriate and necessary to my son or daughter.

After the assessment is completed, the treating clinician will schedule a feedback session with me, either via phone or in person, in order to explain the results of the evaluation and to provide me a copy of the assessment report. I understand that information regarding a client is considered confidential and cannot be disclosed without my written permission. However, there are certain conditions when the staff at the Belin-Blank Center must release information about a client whether or not the client approves. Those conditions are:

1. Suspected child abuse: The staff at the Belin-Blank Center are mandatory reporters of suspected child abuse (physical, sexual, or neglect) and are required by law (Section 232. 69(1) of the Iowa Code) to report suspected child abuse to the Iowa Department of Human Services.
2. Potential homicide or suicide: In instances where a client threatens homicide, the staff at the Belin-Blank Center may have to notify the intended victim and police. Likewise, if a client is deemed a serious risk, family or authorities may need to be notified in order to protect the client from harm.
3. Court Order: If a court of law issues a court order for a client's records, a counselor at the Belin-Blank Center may have to release the records to the court.

I hereby authorize the staff of the Assessment and Counseling Clinic to provide

assessment services to _____.
(print name of minor)

The service is authorized from _____ through _____.
(starting day, month & year) (ending day, month & year)

I understand that I can revoke this consent at any time. Please direct any questions/concerns regarding this consent to Dr. Alissa Doobay (phone: 319-335-6148).

_____ Date_____
Signature of Parent/Guardian

_____ Date_____
Signature of Parent/Guardian

_____ Date_____
Signature of Minor (12 years or older)

_____ Date_____
Signature of Witness

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