BERKSHIRE SCHOOL
AUTHORIZATION FOR CONSULTATION WITH SCHOOL COUNSELOR

Name of Student:_____ Grade:_____ Date of Birth:_____

In my capacity as the parent/legal guardian of the above-named student (the "Student"), I hereby authorize the School Counselor at Berkshire School (the "School") to communicate with the Student on one or more occasions to help facilitate educational, social, and emotional support for the Student. I understand that communication between the School Counselor and the Student may include, but is not limited to, meeting in-person, speaking via telephone, or communicating using third-party video communication applications such as, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype. I understand that, while the School encourages students to inform parents of the decision to see the School Counselor, I may not be automatically notified. I further understand and agree that the School Counselor is not engaged by me, the School, or any third-party mental health or healthcare provider as the Student's private therapist. Should it be in the best interests of the Student to obtain the services of a psychologist or other mental health professional, the School Counselor may assist in a referral for such services from a professional not employed by the School. In the event an outside referral is appropriate or requested, I agree to be financially responsible for all associated fees.

I understand and agree that the School Counselor is part of a team of faculty members and administrators at the School who collaborate with respect to the Student's educational experience at the School. As part of this collaborative effort to support the Student's educational experience at the School, I understand and agree that the School Counselor may share information obtained from me and/or the Student on a "need-to-know" basis with other employees of the School. I further understand and agree that the School Counselor does not seek to engage in therapeutic discussions with the Student that are protected by any mental health professional confidentiality privilege. To the extent such communications between the School Counselor and the Student may be covered by such a confidentiality privilege, I hereby waive that privilege and authorize the School Counselor to communicate with others as deemed appropriate by the School Counselor, including potentially with me and other School employees.

I understand that this authorization: (i) includes the potential for the release of protected health information, and (ii) is subject to revocation at any time upon my written request, except to the extent that the School has already relied upon my authorization. Unless otherwise revoked, this authorization will remain in effect while the Student is enrolled at the School.

I have read this form in its entirety and understand what it means. By signing this form, I affirm that I have legal custody of the Student and am authorized to sign on the Student's behalf. By signing below, I acknowledge and agree that my electronic signature below has the same legal effect and validity as a written signature, and that this form is valid and will be given the same legal effect as a written and signed form.

Signature of Parent/Guardian: _____ Date: _____

Print Full Name of Parent/Guardian: _____

Signature of Student: _____ Date: _____

Print Full Name of Student: _____