

**CONFIDENTIALITY**  
**PLEASE READ CAREFULLY**

Generally speaking, communications between a patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law.

There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient. These occasions include, but are not limited to, the following:

- Belief that child abuse has or may occur
- Belief that an elderly or mentally handicapped person has been or may be abused
- Reports by a patient of possible sexual abuse or exploitation by a previous therapist

An instance where you are felt to pose an imminent danger to yourself or another person may result in a loss of confidentiality. Or, if you make your mental health a point of litigation you implicitly waive the right to confidentiality and your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Similarly, if you are involved in a suit affecting the parent-child relationship, your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Special rules apply to minors: By law, a parent has the right to the medical record of a child, unless this right has been limited by court action. Parents, on the other hand, may agree that during the course of treatment given to a minor child, they will waive the right to the medical record of their child. I have found that this waiver is helpful for useful clinical work to occur.

If you have any questions, or would like additional information please feel free to ask.

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**ACKNOWLEDGMENT BY PATIENT**

I have read the preceding and understand my rights as a patient.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I am willing to waive my right of access to communication between my child and their physician/therapist and grant to the physician/therapist the discretion to determine when or if such communication would be shared by me.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date