Confidentiality Agreement

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1. Purpose

This Confidentiality Agreement explains how your personal health information will be handled and protected during the course of our therapeutic relationship. It outlines your rights regarding privacy and the conditions under which your information may be disclosed.

2. Confidentiality of Sessions

All information disclosed during sessions is confidential. This includes:

- Personal and family history
- Information about mental and physical health
- Details shared about relationships, experiences, and goals

Your privacy is protected under the Health Insurance Portability and Accountability Act (HIPAA) and state laws. The information you share will not be disclosed to third parties without your written consent, except under specific circumstances outlined below.

3. Limits of Confidentiality

While confidentiality is a key component of the therapeutic relationship, there are certain situations where your information may be disclosed without your consent, as required by law:

- **Risk of Harm:** If you disclose intentions to harm yourself or others, the therapist may be required to take protective actions.
- **Suspected Abuse:** If there is suspicion of abuse or neglect of a child, elderly person, or vulnerable adult, the therapist must report it to the appropriate authorities.
- **Legal Requirements:** If required by a court order, subpoena, or other legal process, your records may be disclosed.

4. Use of Information for Administrative Purposes

Your information may be used for:

Treatment planning and case management

Billing and payment processing

Internal practice audits and quality assurance

These activities are conducted in compliance with HIPAA to ensure the protection of your privacy.

5. Electronic Communications

While efforts are made to protect your information during electronic communication (e.g., email, text, telehealth, zoom), please be aware that these channels may not be fully secure. By signing below, you acknowledge the risks and consent to electronic communication if necessary.

I consent to communication via:

☐ Email ☐ Text

☐ Phone

6. Your Rights

As a client, you have the right to:

-Request access to your records.

-Request corrections to inaccurate information.

-Request restrictions on certain uses or disclosures.

-Withdraw your consent at any time in writing, except where action has already been taken based on prior consent.

Client's Signature

By signing this form, you confirm that you understand the information above and agree to the terms of confidentiality as outlined.

X

Print name: **Date:**

Practitioner's Signature	
X	
Print name:	**Date:**