CONFIDENTIALITY POLICY

I will keep confidential anything you say to me, with the following exceptions: (a) Use or disclosure to provide treatment, to obtain payment for services provided, and for other professional activities (known as “health care operations”); (b) Use or disclosure for purposes of my direction and clinical supervision; (c) Use or disclosure of anonymous clinical information for purposes of research; (d) You direct me to tell someone else and you sign a “Release of Information” form; (e) I determine that you are in imminent danger of harming yourself or others; (f) you report information to me about abuse of a child/adolescent, an elderly person, or a disabled individual, and you decide not to report this information to the proper authorities (e.g., DFACS) as mandated by law and the ethics of my profession; or (g) I am court ordered to disclose information. In the latter case, my license does provide me with privileged communication, “meaning that a court order can also be appealed if deemed harmful to you.” I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say to me confidential; or (h) between myself & EAP’s professional staff.

No identifying information regarding your treatment will be released to your employer without a signed Release of Information specifically stating that this may take place.

If you are participating in group or family psychotherapy then please be aware that I cannot guarantee all participants will maintain your confidentiality. By signing this document you are indicating that you will agree to uphold any information learned during a therapy session in the utmost confidence. Likewise, please be aware that I have required each participant in psychotherapy with me to also make this agreement.

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Client Signature (Client’s parent/Guardian if under 18) Today’s Date