heartsandmindshealth
licensed mental health services in NOVA and Metro DC

CONFIDENTIALITY AGREEMENT

All client information is confidential and will not be released to any third party except in the following cases:

- **When medical information is necessary to process an insurance claim or at the specific written request of the client.**

- **When non-disclosure would directly jeopardize the life or safety of the client or others.**

During the course of therapy, any direct revelation of abuse/neglect of children or the elderly is required by law be reported to proper authorities. In addition, if the client presents to be at critical risk for suicidal (harming oneself) or homicidal (harming another person) behavior, it is understood that the clinician must take actions to protect the client and/or other persons who might be at risk of physical harm. The actions will include notification of significant others, such as relatives and close friends of the client and notification of the client's psychiatrist and/or primary care physician. Finally, if required by court order, therapist may provide testimony to comply with specific legal requests. If the therapist determines that the client is immediately at risk for self/other destructive behavior, the therapist will ask the client to participate in an immediate, voluntary psychiatric evaluation of suicidal and/or homicidal risk. If the client refuses to cooperate with a voluntary assessment, the therapist will contact municipal police to facilitate custodial intervention in order to effect a psychiatric evaluation. Non-compliance with requests of the therapist in managing at-risk situations may result in a decision by the therapist to terminate treatment. In this case, the therapist shall have no further obligation to the client. In the event of police notification in circumstances where there is risk of harm to others, the names of the potential victims will be provided to police by the therapist in order to effect protective notifications and action.

I the undersigned client, have read and discussed the above policy with my therapist, Michael Payne, MSW, LCSW, LICSW, and agree to the release of personal and clinical information regarding me should the therapist deem it necessary in order to protect myself or others from potential suicidal, homicidal, and/or abusive behavior. I understand that failure on my part to cooperate with the therapist in the management of potentially at-risk behavior on my part shall be grounds for termination of psychotherapy by the therapist with no further obligations of the therapist to me beyond the actions described above.

Client Signature	Printed Name	Date

Co-Signature	Printed Name	Date