Confidentiality Agreement

Date: __________________________

I, ____________________________________________________________, understand that all information regarding counseling is confidential and will not be released to any other agency or individual without my prior knowledge and written consent, except when required by law.

These exceptions include but are not limited to:

1. When a client has communicated to the clinician an explicit threat to seriously physically harm another person.
2. When a client presents a clear and present danger to him/herself and refuses to voluntarily accept further appropriate treatment.
3. When a client raises a history of violence and a psychological disorder as an element of his/her claim or defense.
4. Reports of instances of suspected child abuse and neglect.
5. Psychological notes and records will be maintained in your file.

I further understand that my counselor may consult with other staff members in Counseling Services in order to provide the best service possible for me. I understand that my counselor may also consult with Health Services if medical consultation is necessary.

I understand that any counselor who is not yet licensed in Massachusetts is required by law to be supervised. Therefore, my situation may be discussed with my counselor’s supervisor. The intention of the supervision is to promote the highest quality services to me and to insure the highest quality trained staff to offer those services. At all times, my privacy and care will be treated with the highest regard and my confidentiality insured.

*Please list a person we can notify in case of emergency:

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I have read and understand the above confidentiality agreement and limitations to confidentiality.

Client Signature: _______________________________________

Print name: ____________________________________________

Witness Signature: _____________________________________

Print name: ___________________________________________