Patient Confidentiality Agreement

Date: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Dear [Patient's Name],

As a mental health practitioner, I am committed to protecting your privacy and the confidentiality of your personal information. This confidentiality agreement outlines our mutual understanding regarding the safeguarding of your information.

Confidentiality Clause:

1. All information shared during therapy sessions will be kept confidential except under the following circumstances:

- If there is a risk of harm to yourself or others.
- In cases of child abuse or neglect.
- When the court orders disclosure of information.

2. Your consent will be obtained before sharing any information with third parties, such as other healthcare providers or family members, unless required by law.

3. You have the right to access your records and request changes if you feel that information is inaccurate.

Please sign below to acknowledge your understanding and agreement to the terms of this confidentiality agreement.

_____

Patient Signature

_____

Date

_____

Practitioner Signature

_____

Date