

# Counseling Center of Expressive Arts

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## LIMITS OF CONFIDENTIALITY

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The laws of the State of Texas require that most issues discussed during the course of therapy with mental health providers are confidential. These laws permit you to waive privilege of confidentiality by signing a "Release of Information" form. However, there are situations when your confidentiality is not guaranteed. These situations include the following. Please **initial** the lines below indicating your agreement with these limits of confidentiality.

- \_\_\_\_\_ 1. Under certain circumstances your file can be subpoenaed by the courts
- \_\_\_\_\_ 2. If you intend to harm yourself or someone else and verbalize this threat, I am permitted by law to notify the proper authorities, and you hereby grant me permission to do so
- \_\_\_\_\_ 3. Any report of injury to a child, an elderly person or a disabled person, must be reported to the proper authorities
- \_\_\_\_\_ 4. I may consult with another counselor about your case. Every attempt is made to ensure identity remains anonymous. In addition, the counselor with whom I consult is held to the same limits of confidentiality outlined here
- \_\_\_\_\_ 5. If you are a minor, your parent(s) are the holders of confidentiality.  
In other words, everything a minor tells a counselor can be told to the parent(s). However, in order to work most effectively with a minor, I request that the parent(s) allow me to determine what I will disclose to them. If your parent(s) agree, I will then inform your parent(s) only of any life threatening activity. In that event all other information discussed by you with me in counseling will be kept confidential.
- \_\_\_\_\_ 6. I may be required to disclose certain information concerning your diagnosis, prognosis or treatment to third party payers such as health insurance providers, EAPs, HMOs and PPOs in order to secure insurance payments from these providers.

Sign and date this form in the space provided below. This will confirm that I have informed you of the limits of confidentiality and that you have agreed with these limits. Thank you.

\_\_\_\_\_  
Signature of Client (or person acting for client)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to client (if necessary)

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date