LIMITS OF CONFIDENTIALITY
EMDR Consultation and Therapy Services
Cossette D. Ahlborn

Clients are often unsure about what to expect from their first visit or consultation with a Behavioral Health Provider. I encourage you to consider the following points regarding your care, and to discuss them with me if you wish. You can expect the attention, respect and best professional efforts of from me. I will treat you as a responsible individual and will expect you to take an active part in your treatment. You should also expect to take part in the treatment decisions. You should understand the goals and direction treatment is taking, and if you do not understand, you should ask. Before initiating a professional evaluation or treatment relationship with me, I want you to know about privacy ground rules.

Generally, information discussed during your evaluation and treatment sessions is confidential and may not be released to anyone outside of this practice without your permission. In other words, in most circumstances, a release of your medical information requires your consent. However, under some limited circumstances, your information may be released without your permission. I will review these possible circumstances with you, but please notify me if you have any immediate concerns.

Please read each statement and sign below:

1. Your care is documented in your Electronic Medical Record and paper chart is maintained at this office.
   Professional Colleagues I have designated, in an agreement for Consultation, would have access to your medical record to ensure consistent, quality care. Additionally, these colleagues may have access to your medical record for quality assurance reviews. We may also share information with other medical providers and case managers for the purpose of treatment planning and coordination of care.
2. Suspected Abuse/Neglect/Sexual Abuse of Children, Spouses/Intimate Partners and Vulnerable Adults.
   Healthcare providers are mandated by state law to report suspected child abuse/neglect/sexual abuse; spouse/intimate partner abuse/neglect/sexual abuse; and vulnerable adult abuse/neglect/sexual abuse. Suspected incidents must be reported to proper authorities such as Child and/or Adult Protective Services.
3. Crimes or Fraud.
   Providers must report any threat to commit crimes or fraud or any serious intentions to violate the law.
4. Danger to Self or Others.
   Providers must take steps to protect individuals from harm when the client presents a serious threat to the life or safety or self or others.
5. Drug and Alcohol Abuse
   Providers must take steps to protect individuals when there is suspected instances of drug/alcohol abuse or such dangerous behaviors if they present a danger to the individual or others.
6. Information Provided in Our Electronic Paperwork System.
   This information may be used for medical research purpose without disclosure of any of your personal identifiers.
7. Investigations.
   If you are under investigation, we may have to release relevant information if requested. At times, dependent on your job situation; military, airlines, security jobs, police etc.. and Security Clearance investigators are able to request/review your records. Records may also be subpoenaed by civilian courts.
   Release is coordinated with legal consultation to ensure only relevant information is released and efforts will be made to protect the confidentiality of your record.
8. Report of Sexual Assault.
   If you disclose that you have been sexually assaulted dependent on the situation we may be required to notify a Victim Advocate in the Community who will inform you of your rights regarding an assault.

I have read the above Behavioral Health Limits and Confidentiality and understand that my medical information will be safeguarded within the above described limits and in accordance with this policy.

_____	_____	_____
CLIENT NAME (PRINT)	CLIENT SIGNATURE	DATE

I have inquired to ensure the client understood the above description of the Limits of Confidentiality.

_____	_____	_____
HEALTH CARE PROVIDER NAME (PRINT)	HEALTH CARE PROVIDER SIGNATURE	DATE

_____	_____	_____	_____
CLIENT NAME (PRINT)	DOB	SSN	