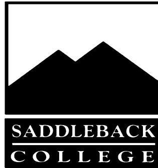

SADDLEBACK COLLEGE STUDENT HEALTH CENTER

CONSENT FOR PSYCHOTHERAPY
Limitations on Patient Confidentiality
AND
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

We greatly respect your right of privacy regarding information you share in therapy. We also believe you should fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you disclose in therapy.
We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to and/or enable anyone to commit a crime, or avoid detection or apprehension.
3. Your therapist was appointed by the court to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is part of a proceeding to establish your competence.
6. The contact is one in which your psychotherapist must file a report to a public employee or the information is required to be recorded in a public office, if such report or record is open to public inspection.
7. You are under 16 years old and you are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are a victim of child abuse.
9. You are over the age of 65 years and your psychotherapist believes you are the victim of physical abuse; your therapist may disclose information if you are the victim of emotional abuse.
10. You die and the communication is important to decide an issue concerning a deed of conveyance, will, or other writing executed by you affecting an interest in property.
11. You die and the communication is important as to your intent related to deed of conveyance, will, or other writing executed by you.
12. You file suit against your therapist for breach of a duty or if your therapist files suit against you.
13. The communication is important to an issue between parties claiming through you after you have died.
14. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
15. You waive your rights to privilege or give consent to limited disclosure by your therapist.

If you have any questions about these limitations, please discuss them with your therapist. Your therapist will strive to maintain confidentiality of information gained from you in the course of treatment. It is important, however, that you fully understand these circumstances in which disclosure could occur.

I, the undersigned patient and/or legal guardian, authorize treatment by counseling staff at Saddleback College Student Health Center. I have read, understand and, agree to the above limitations on patient confidentiality.
Please Note: The Health Center is not a 24-hour care facility. If an emergency occurs after normal business hours, seek immediate medical or psychological attention at the nearest emergency room or call 911.

I further understand that Saddleback College Student Health Services will provide me with a paper copy of their Notice of Privacy Practices at my request. I understand that this notice contains information about how my **PHI** (protected health information) will be protected and my rights as a patient.

______________________________	______________________________
Print Patient Name	Date
______________________________	______________________________
Signature	Witness

bmf: 4/09