East Valley COMMUNITY HEALTH CENTER

Behavioral Health Department
Limits of Confidentiality and Consent

Limits of Confidentiality and Consent for Behavioral Health Services

1) I understand that my therapist may be an intern or graduate from a MSW, MFT, or equivalent degree program who is being supervised by a therapist licensed as a Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or a psychologist (PhD/PsyD) with a license in psychology or other board licensed discipline for psychotherapy. An intake may be conducted by a staff member with a BSW or equivalent degree.
2) I understand that the therapy sessions are confidential, with the exception of information related to suspected or known child or elder abuse and/or neglect, or if I am considered a danger to myself or to others, at which time a report may be required.
3) All client records are property of East Valley Community Health Center and information contained therein may be shared with the Medical Care team for continuity and integration of care.
4) Other medical facilities and pharmacies may obtain our medical records without consent.
5) I understand that my records can be obtained by other professionals, outside of the agency, only with my written consent of release of information.
6) Each individual counseling session is approximately 30 minutes in length.
7) Behavioral Health Department does NOT fill out SSI paperwork or Disability.
8) I consent to participate in telehealth as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telehealth.
   a) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
   b) I understand that there are risks, benefits, and consequences associated with telehealth including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
   c) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
   d) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
   e) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
   f) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at to discuss since we may have to re-schedule.
   g) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency to respond to my location and address. I agree to inform my therapist of my current location and address at the beginning of each session and to allow my therapist to call the person below in a life-threatening emergency only. This person will be contacted to go to my location and take me to the hospital in the event of an emergency. I will provide my intended location and address below but will confirm my current location and address at each session.

My Intended Telehealth Location/Address ____

Emergency Contact Name _________________________________ Relationship _______________ Phone _______________________

I have read and understood the above. I understand the information contained in this form and all of my questions have been answered to my satisfaction. I give consent to receive counseling/therapeutic services at East Valley Community Health Center. Inc.

___________________________	_________________________________	_________________________	________________
Print Patient Name	**Signature of Patient or Patient's Representative**	**Relationship to Patient (If not self)**	**Date**

___________________________	_________________________________	________________
Print Witness Name	**Signature of Witness**	**Date**