Confidentiality Agreement

While receiving services at _____ Facility, you have the right to decide who may and who may not receive information about your presence and treatment in this facility. This form is for you to document your choices. Please initial indicating your choice in the following areas:

Visitors:

_____ I choose to have visitors.

_____ I choose to limit the specific visitors to the following:

_____

_____ I choose to have no visitors.

Telephone Use:

_____ I choose to receive all phone calls.

_____ I choose to limit my calls to specific callers, including:

_____

_____ I choose to receive no phone calls.

Medical Records:

_____ I choose not to limit access to my medical records.

_____ I choose to limit access to my medical records to the following:

_____

_____ I choose that my records be accessible only by staff and people in the profession involved in my treatment.

Other:

☐ I understand that federal and state laws, courts, and medical conditions may limit any of the above decisions.

☐ I understand that though these are my present choices, I may change this document at any time, and that it will be placed in my clinical record while treatment continues.

_____ _____

Signature of Individual Printed Name of Individual

_____ _____

Date Name of Witness