



Wellness Center

## CONFIDENTIALITY AGREEMENT

### PLEASE READ CAREFULLY!

What you discuss during your appointment with any professional within the Wellness Center is **confidential**, including the fact that you have come to the Wellness Center at all. There are some **exceptions**. As part of the multidisciplinary services offered to you, your nurse, counselor, physician or medical technician may consult with other members of the Wellness Center professional staff. Because we are in an academic setting, clinical psychology students, nursing students or social work students who are doing a part of their clinical practicum in the Wellness Center, along with their clinical faculty, may have access to your record as a part of their professional clinical experience. University departments involved in Wellness Center billing will know that you have obtained service but not the nature of that service. Outside referral labs may need some diagnostic information about you in order to process your lab tests. These disclosures are a part of regular business operations.

**Typically, only with your written consent can information about you be disclosed outside of the Wellness Center.** There are rare occasions when the Wellness Center will be required by law to disclose certain information about you without your consent. Some examples of these occasions include:

If you report your imminent intent to seriously injure or kill yourself or another. Disclosure will be made to protect you or others.

If you disclose current child abuse, state law requires that this be reported to the Department of Children and Family Services.

A civil or criminal proceeding which results in a subpoena or Court Order for disclosure of information about your physical or mental health treatment. The Wellness Center might have to disclose some information about you to comply with the subpoena or Court Order.

The certainty of a swift response cannot be assured when e-mail is used, Wellness Center policy is that no contact takes place via e-mail regarding your treatment.

You have the right to review your medical or psychiatric record with a Wellness Center professional and make a copy of your record.

Your signature below indicates (1) your understanding and acceptance of the Wellness Center confidentiality policy and the limits of confidentiality; (2) your consent to the types of disclosures that are contemplated in this agreement; and (3) that you have had an opportunity to ask questions. If you do not accept these policies, you may request a referral to an outside agency.

Signed \_\_\_\_\_  
Witness \_\_\_\_\_

Date \_\_\_\_\_  
Date \_\_\_\_\_