LIMITS OF CONFIDENTIALITY

Counseling Services Provided by: Dr. Deborah Wieland, PsyD, LMFT

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Counseling is both a confidential and professional relationship. What you communicate during treatment is protected by legal, professional, and ethical standards. Information gathered in the course of treatment may not be released without your prior written consent. However, California Law has placed specific limits on the confidentiality of the therapeutic relationship.

According to California State Law, this Therapist has a legal obligation to limit/breach confidentiality under the following situations and conditions:

1. When a client communicates a serious threat of physical violence against a reasonably identifiable victim(s). (Tarasoff, Civil Code 43.92)
2. When a therapist knows or reasonably suspects a child is being abused (physical, emotional, sexual) or seriously neglected (medical, food, clothing, shelter) (Penal Code Section 11165)
3. When a therapist has reasonable knowledge that a person over age 65 or a dependent adult has been abused (physically, emotionally, financially) (California State Law)
4. If requested by the patient or compelled by order of the Court

Confidentiality may also be limited/breached in the following situations:

1. When the Therapist determines or has reasonable cause to believe, the client is in such mental or emotional condition as to be a danger to self or another (suicidal/homicidal), and disclosing confidential information is necessary to prevent the threatened danger. (Evidence Code 1024)
2. In threatened suicide/homicide cases, the Therapist has a legal duty to protect and take reasonable steps to prevent harm (Even if reported by a family member- Ewing Civil Code 43.92).
3. When the Therapist believes there is reasonable suspicion of Child, Elder, or Dependent abuse.

I have read this statement and fully understand the contents. I agree to these limits of confidentiality and will not hold the Therapist liable for breach of confidentiality under the conditions stated above.

Signature: _____ Date:_____

Signature: _____ Date: _____

As a minor, I give the therapist permission to share information with my parents/guardians as is deemed necessary throughout the treatment process

*Minor's Signature: _____ Date: _____