



CONSENT FOR TREATMENT AND LIMITS OF CONFIDENTIALITY

State Form 48429 (R / 6-12)
DEPARTMENT OF CORRECTION

CONFIDENTIAL

MENTAL HEALTH SERVICES CONSENT FOR TREATMENT and LIMITS OF CONFIDENTIALITY Understanding and Agreement

Mental Health Services staff provide counseling and psychological evaluations for offenders in this facility. The mental health staff wants you to feel comfortable in discussing your personal concerns with them, but you need to be aware of special situations in which confidentiality will be limited.

Security and safety are very important in jails and prisons. To ensure the safety of everyone, mental health staff must report situations which could be harmful to yourself or others, or a threat to the orderly operation of the facility, such as, but not limited to:

1. Escape planning
2. Planned violence toward others
3. Risk of suicide
4. Hunger strikes
5. Drug sale or trafficking during incarceration
6. Inappropriate relationships with staff
7. Child abuse or neglect
8. Behavior that endangers another person

For many problems and concerns, group settings are the best mode of treatment or intervention. However, while mental health staff encourage all group members to follow the instruction to keep anything said during group sessions to themselves, we cannot guarantee that information discussed during group counseling will not be shared by group members with others. You need to be aware that confidentiality leaks can happen. Offenders found to sharing information from the group with others may be removed from the group.

Progress notes regarding your attendance, level of participation, and treatment progress will be entered into your health record. This information will be released under the same conditions as any other health care treatment information.

I have read the information above and have been given the opportunity to ask questions about the limits of confidentiality. Having understood and agree to the above, I hereby apply for mental health treatment.

Signature of offender / student	Printed name	Date (<i>month, day, year</i>)
Signature of staff and title	Printed name	Date (<i>month, day, year</i>)
Signature of Superintendent (<i>juveniles only</i>)	Facility	Date (<i>month, day, year</i>)

PATIENT IDENTIFICATION	
Full name	
Number	
Date of birth (<i>month, day, year</i>)	Lock: