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Confidentiality

Communication between a patient and their psychologist is privileged and confidential. This means that the clinician can not discuss a case, orally or in writing, without the written permission of a patient.

Some state laws specify there being special circumstances when a mental health professional may be required to break confidentiality. These circumstances include when a person is a threat to themselves (such as being suicidal). Being a threat to others (such as homicidal) is another instance where confidentiality can be broken. A third situation where state laws may require breaking confidentiality is when someone is suspected of being abusive to others, such as children, the disabled, or elderly. A fourth possibility is if court requires it. This typically happens when you are involved in a lawsuit.

It is also understood that Dr. Glenn Cahn may seek peer consultation of my case. This is a common professional activity that is permitted under the laws governing therapist/patient confidentiality. Such consultation does not require specific consent from the patient. My confidentiality is maintained between Dr. Cahn and from whomever he may seek consultation. If consultation is sought in my case, it is intended to serve my best interest.

Reasonable efforts will be made, when clinically appropriate, to discuss and/or resolve these issues before such a release of information takes place. The appropriateness of such discussions will be within the sole discretion of Dr. Cahn. Your signature below indicates that you have read and understood these statements.

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I hereby give permission to Dr. Cahn to release a complete copy of his psychological test report, on me or on _____ to whom I am a parent/guardian. This authorization will last for six months from the date shown below unless otherwise specified as ending on: _____. I understand that my information may not be protected from re-disclosure by the recipient of this information.

This information should be released to: (specify name/agency, phone and/or address):

1)_____

2)_____

3)_____

I understand that I may revoke this authorization at any time, but I understand that any authorized release of the information prior to that revocation can not be undone.

_____ _____

Signature (parent or guardian for a minor) Date