

# Virginia Clinical Therapy Center

## Confidentiality Policy for Adolescents in Psychotherapy

In keeping with the Position of *The Society for Adolescent Medicine* and *The American Medical Association* regarding Private and Confidential Health Services for Adolescents, our policy regarding adolescent confidentiality is as follows:

**Confidentiality** is an agreement between a client and a therapist that information discussed during or after a session will not be shared with other parties without the explicit permission of the client. Although parents are legally entitled to information shared in counseling their children, I have found that candid and complete information can be gathered only by speaking with the adolescent alone, and by clarifying with whom the information will be shared. Adolescents are more likely to share their history of risky behaviors and I am better able to provide an accurate diagnosis and suggest appropriate treatment, when they trust that I will keep their confidences.

Adolescents seek confidentiality for many reasons. Some fear parental retribution; others fear damage to reputation and self-esteem; but most adolescents are striving for maturity, independence and adult status. Adolescents seek privacy in discussing these sensitive topics and may worry about parental disapproval.

When deciding what information to share with parents, I take into account the adolescent's developmental abilities, the presenting problem, and the adolescent's individual needs. Confidentiality helps build trust by allowing me to demonstrate respect for your child as an individual while stating that I may find it necessary to share information with parents in certain circumstances where serious health and well-being issues are in jeopardy. **Federal and state statutes maintain the confidentiality of medical information for adolescents.**

### Legal Limits of Confidentiality

There are circumstances in which it is neither possible nor appropriate to maintain the confidentiality of information for legal and other reasons. These include situations in which the adolescent poses a **severe risk of harm to himself or herself or to others**, and cases of suspected **physical or sexual abuse** for which there is a legal reporting requirement. However, when confidentiality must be breached for ethical or legal reasons, your child will be informed in advance and we will make a plan to share this information with you.

I ask that you allow your child and I to develop a relationship based on trust and honesty. Again, if your child is in **any** danger, I will develop a plan with his or her permission to make you aware of this situation as quickly as possible.

**I agree to allow the therapists at Virginia Clinical Therapy Center to meet with my child individually and to maintain confidentiality regarding information shared unless that information would negatively affect the health and safety of my child or others.**

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Adolescent Signature \_\_\_\_\_

Date \_\_\_\_\_