

Therapy Client Confidentiality Preference Form

Client Name

Contact Email

Preferred Method of Communication

☐ Email ☐ Phone ☐ Text Message ☐ Video Call ☐ Other

Preferred Level of Confidentiality

Authorization to Share Information Do you authorize your therapist to share your information with any of the following?

☐ Primary Care Doctor ☐ Family Member ☐ Emergency Contact ☐ None

Additional Confidentiality Preferences or Restrictions

Signature

Date