Giovanna M. Cammuso, LCSW
312 Main St.
Southinton, CT 06489
(860) 919-7136 / GMC.LCSW@gmail.com

Patient Name: _____

Patient DOB: _____

PATIENT AND VISITOR CONFIDENTIALITY AGREEMENT

I understand and agree that, during the course of any visits to the office of Giovanna M. Cammuso, LCSW, any information learned by me (e.g., while entering/leaving the premises) about any patient or family member of a patient is strictly confidential.

This confidential information, including the fact of an individual's participation in treatment, is subject to protection by State and Federal laws that safeguard the rights of patients at psychiatric facilities.

I understand and agree that any discussion or disclosure I make about other patients or family members of patients of Giovanna M. Cammuso, LCSW constitutes a breach of confidentiality. I further acknowledge that the Giovanna M. Cammuso, LCSW is not itself legally liable for any unlawful disclosures of confidential information that I may personally make.

I have read and understand this Confidentiality Agreement and agree not to discuss or disclose any information learned about other patients or family members of patients at the Giovanna M. Cammuso, LCSW.

By signing this form, I acknowledge that:

- ☐ **I have reviewed the Confidentiality Agreement carefully and was offered a copy for my records.**
- ☐ **The information contained on this form has been explained to me in language that I can understand.**

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

_____ _____
Patient Name (PRINT)

_____ _____
Staff Name (PRINT)

_____ _____
Parent/Guardian/Conservator Signature Date

_____
Parent/Guardian/Conservator Name (PRINT)

STAFF USE ONLY

☐ Emergency admission _____ *(initial)*

☐ Refusal to acknowledge _____ *(initial)*