

## Consent and Confidentiality Agreement

Group medical appointments provide a forum for growth and healing that is distinct from what is experienced in individual appointments. Group provides a testing ground in which each person can talk freely with others about concerns in order to better understand themselves and to learn new ways of thinking, feeling, and acting.

Group medical appointments involve patients sharing private medical and psychological information in the presence of other patients and family members. Your health care providers may release medical and psychosocial information about you and/or your family members that will be heard by other members of the group. In some cases this may be sensitive information.

You have the right to privacy and you may decline to share information with this group. If you do not want certain information discussed by your health care providers, please specifically indicate in the comment section below what information you do not wish to discuss in group setting.

Comments: \_\_\_\_\_

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Please note that participation in the group is completely voluntary and confidentiality will be addressed and respected.

I consent to be treated by the medical professional in a shared medical group.

I DO NOT consent to be treated by the medical professional in a shared medical group; I would like to be seen individually.

Initial X \_\_\_\_\_

### Participants Responsibilities and Rights

Participation in any group activity, exercise, or discussion is at all times, up to each individual group member. However, how much you gain from your time in group will depend upon your willingness to give of yourself and take some risks in the group. Some areas that might require extra effort and commitment are: willingness to honestly share your thoughts and feelings; listening earnestly and thoughtfully to others; demonstrating openness to feedback from others; keeping what is said and done in group confidential.

I, \_\_\_\_\_ understand that group member's names and comments/discussion that occurs within the group are confidential. By signing this agreement form, I agree to maintain the confidentiality of all members of the group.

Patient's Signature: \_\_\_\_\_

Print name: \_\_\_\_\_ Witnessed By: \_\_\_\_\_