

Jennifer Ritchie-Goodline, Psy.D.

Licensed Clinical Psychologist



6065 South Quebec Street, Suite 202 | Centennial, CO 80111 | Phone 720.299.8342 | Fax 303-779-0327 | [Email](#)

Confidentiality Policy for Family Therapy

This document contains important information about my confidentiality policy when working with families in treatment. It is important to be aware that when I am treating a family in therapy, I consider the family as a whole to be my client. As such, confidentiality is to the family in its entirety, not to any one member of the family individually. During the course of treatment, I may see members of a family individually or only a portion of the family (i.e., two siblings, one parent and child, etc.) for therapy sessions. These sessions should be seen by you as part of the family treatment we are doing, unless otherwise indicated. If you participate in one of these sessions with me, please understand that these sessions are confidential in the general sense. However, these sessions are not confidential from the other members of the family. I will not “keep secrets” or withhold information from the other members of the family. Withholding important information learned during an individual session or a session with only a portion of the family present may actually serve to negatively impact both our therapeutic and your family relationships and undermine family treatment. In fact, it may be essential to address information and issues disclosed in an individual session or a session with only a portion of the family present with the other members of the family in order for treatment to be effective. I will use my clinical judgment as to how, when, and to what extent such disclosures to the other members of the family will be made, and, if appropriate, first give the individual or the appropriate portion of the family the opportunity to make the disclosure. Therefore, if you find it necessary to disclose information that you do not want to be shared with other members of your family, you may want to consult with another therapist who will treat you individually (I can provide a referral to an individual therapist for you if needed).

Please note, this policy also applies to information shared between sessions via telephone and/or e-mail.

I have read and understand the above information and I enter family therapy in full agreement with this policy.

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Signature _____ Date _____