

## **ACKNOWLEDGEMENT OF LIMITED CONFIDENTIALITY AND WAIVER**

I, \_\_\_\_\_, have been informed and acknowledge that I have limited rights of confidentiality regarding my treatment at the Counseling Service of Any County.

I understand that the purposes of this waiver are for coordinating and planning my treatment, protecting the community from my sexually aggressive behavior, and repairing damage perpetrated on my victims by my sexually aggressive and other abusive behavior.

I consent to unrestricted communication between the treatment staff at the Counseling Service of Any County and the Department of Corrections personnel responsible for my supervision. I also consent to unrestricted communication between treatment staff and any other individual or agency with whom treatment staff judge communication is necessary in order to achieve the purposes stated above. I understand that these individuals or agencies may include, but are not limited to, the court, the victim, and Social and Rehabilitation Services.

I also understand that treatment staff are obligated under state law to report acts of abuse towards children, the disabled, and the elderly. There is also a general obligation of treatment staff to inform the authorities or others if, in the professional opinion of staff, my behavior presents a clear and imminent danger to either myself or other persons.

I understand that sexually aggressive behavior is criminal conduct that has serious consequences to the victim and the community. I want to control my sexually aggressive behavior, and I wish to be held fully accountable for my behavior.

I acknowledge that this waiver is signed without threat, promise, or coercion and is a voluntary act on my part.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date