BRING EVERYONE IN THE ZONE, INC. (BEITZ)
CONFIDENTIALITY STATEMENT

I (print full name) ____ promise that I shall hold in confidence, all information shared during group meetings. I will not violate confidential relationships between group members, facilitators, or guest speakers. I accept full responsibility for maintaining the confidential & private nature of all information. I understand that I am personally responsible and liable for any violation of this agreement. In the event I break confidentiality, I understand that I may no longer attend group meetings.

There are several specific reasons that may require a BEITZ Facilitator to disclose your information. In those instances, I pre-authorize disclosure of the following information.

When there is disclosure of child or elder abuse.
When a peer expresses the desire and/or plan to injure him or herself.
When a peer expresses the desire and/or plan to harm others.
When there is a need to discuss a peer's session content with a supervisor.
When collaboration is necessary from another provider or partner organization to assist me.
When records are the property of a contracting agency such as a county mental health agency.

Signature: ____ Date: ____________________

Application for Peer to Peer Support Group Membership

Name (please print): ____

Address: ____

City: ____ Zip: _________________

Phone: _______________________ Cell Phone: __________________________

E-mail: ____

Do you want to be notified of meetings by email? YES NO

Partially funded through United Way of Greater Fort Hood Area Grant and Central Counties Services Military Veteran Peer Network Grant

Circle One: Active Duty Guard Reserves Veteran Spouse Dependent Non-veteran

Conflict*:_____________________________________ Years Services From __________ to __________

*Viet Nam, Dessert Storm, Bosnia, Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), Operation New Dawn, Etc.

Would you require a referral for professional counseling? ( ) Yes ( ) No

Your responses will be compiled with others to document the need *for* support group services for Texas Mental Health Consumers & reflect the number of individuals served. All information will remain confidential.

Emergency Contact Information: ______________________________________
Contact Person's Name

____
Contact's Number

How did you hear about us? ____
Newspaper, Caseworker, VA, Vet Center, Medical Facility, Other-please specify

"If you think you can or you think you can't, you're right". Henry Ford

Revised: 3-2-2023