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| --- |
| **CONSENT** |

I,       give my consent for my child’s:

Assessment and Plan to proceed

for information about my child’s mental health being shared with between my treating GP and the clinician/counsellor:

for information about my child’s mental health being shared with other nominated services to ensure collaboration in his/her care as listed below:

|  |  |
| --- | --- |
| **Name** | **Role** |
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to participate in service experience / satisfaction survey and evaluation

for deidentified information to be collected by the funder – (select which PHN) PHN and Department of Health for statistical and reporting requirements.

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**Guardian’s Signature: Date:** /     /

|  |  |
| --- | --- |
| **ASSESSING CLINICIAN** | |
| **Name** |  |
| **Date:** | /     / |

**Clinician Signature:**