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| **CONSENT** |

I,       give my consent:

[ ]  for this Assessment and Plan to proceed

[ ]  for information about my mental health being shared with between my treating GP and my clinician/counsellor:

[ ]  for information about my mental health being shared with other nominated services to ensure collaboration in my care as listed below:

|  |  |
| --- | --- |
| **Name** | **Role** |
|        |        |
|        |        |
|        |        |
|        |        |

[ ]  to participate in service experience / satisfaction survey and evaluation

[ ]  for deidentified information to be collected by the funder -  PHN and Department of Health for statistical and reporting requirements.

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**Client Signature: Date:**      /     /

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

 \_\_\_\_\_\_\_\_

**Clinician Signature:**