|  |
| --- |
| **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.

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

**Client Signature: Date:**      /     /

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

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

**Clinician Signature:**