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**FOR ONLINE SESSION**

**Parental Consent to Treatment and Confidentiality Agreement Form**

For use where clients are under 13 years of age.

**Your therapist: Catriona Mason**

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| **Statements of understanding** | Please tick |
| I give permission for ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name) to receive treatment using the human givens approach to counselling and psychotherapy. |  |
| I understand that all clinical information shared with my therapist will remain confidential within their service except where they believe there may be a risk of harm to my child or others, or where there’s a legal duty of disclosure. |  |
| I understand that my therapist has case supervision with their supervisor where a broad outline of my child’s case may be discussed as a part of the supervisory process, and that no identifying details will be revealed. |  |
| I have read and understood the **HGI** **Information for Clients** sheet including the section about use of questionnaires and how the data will be used in service evaluation and research, and I understand that by ticking the box opposite I am giving permission for my child’s anonymised data to be used for service evaluation and research and that I can withdraw my consent to this at any time by contacting my therapist. |  |
| I understand that my personal information will be kept in accordance with the Data Protection legislation. By ticking the box opposite, I consent to information about my child being held by the therapist, which means that they will:   * use my contact details only to get in touch with me about matters relating to my child’s treatment, such as appointments and to provide helpful information, where appropriate. * not share my child’s personal information with other individuals or organisations, except where they have reason to believe that my child or others to be at risk of harm, or where there is a legal duty to disclose it, or as otherwise specified in this document. * retain a record of my child’s treatment for a period of 7 years, in accordance with professional requirements and will take steps to ensure the accuracy and security of the record. * provide me with access to the information they hold about my child, if I request it. |  |
| I give permission for the therapist to put my child’s name and contact details into an online calendar programme which sends out appointment reminders | Yes  No |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you would like to view this agreement in large print format, please inform your therapist.