

## PSYCHOLOGICAL INFORMATION CONSENT FORM

Information disclosed to your Psychologist, during your therapy sessions, should remain confidential, as outlined in the Health Privacy Act and the Psychological Code of Ethics.

There are two exceptions to the rule of confidentiality.

- (1) In the event that information you have given suggests that you or another identifiable person may harm themselves, others, or are at risk of harm, the Psychologist has a duty of to take action to prevent harm being done. In most cases, the Psychologist will speak with the client before taking any action.
- (2) If a Court of Law issues a subpoena for a Psychologist to testify, or provide information, to the court; the Psychologist must make the information available. It is possible for the Court Attendant to solely have access to certain information, if it would be to the detriment of the client to have the information disclosed in Court. Information of this nature is discussed with the client prior to the Psychologist attending Court.

It is also important that the Psychologist is able to liaise with other relevant health professionals, in order to provide the best possible care for the client. For the Psychologist to be able to contact other health professionals regarding the client, the client must give written consent.

If you would like me to be able to discuss relevant information with your doctor or other health professionals, please sign and date the form below. If there is any information you do not wish to be disclosed to your doctor, please inform me during your session.

Patient records are stored securely on site. They can only be accessed by the health professionals working under Peninsula Clinic and our reception staff. All material is treated as strictly confidential. The practice has an alarm and employs a security service. If you have any concerns regarding your privacy, please speak with me directly.

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I, \_\_\_\_\_, consent to information, relevant to the treatment of my psychological and physical health, that I have provided to Dr. Thane Camwell during therapy sessions, to be discussed with my medical practitioners and other health professionals, as listed below. I have the right, at any time, to request that specific information remain confidential between Dr. Camwell and myself. I understand how my confidential information is stored and accessed within the practice.

Please list practitioners with whom I may discuss relevant information.

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Signed: \_\_\_\_\_  
(Client Signature)

Date: \_\_\_\_\_