

## Client Confidentiality Consent Form

Footsteps therapy and cognitive development service requires a minimum of 24 hours notice should I be unable to attend my appointment. I understand and agree that if I do not attend my appointment, and/or repeatedly do not provide notice, this will compromise the booking of further sessions.

### Recording Information

Our record keeping practices comply with the Non-Government Service Provider – Basic Recordkeeping Guide (Version 5.2 – Oct 2013).

### Access

As part of providing a service, your therapist will need to collect and record personal information that is relevant to your current situation. As mentioned above this information will inform the therapy process and only be used for that purpose. You may access the material recorded in your file upon request, subject to the exceptions in National Privacy Act.

We value your privacy. All information collected about you and held at this service is kept in the strictest of confidence. Under the National Privacy Principles Amendment Act No. 115 (2000) and Act No. 119 (1988), we remain committed to protecting your privacy and seek your expressed consent for the use and disclosure of your personal health information in the course of your therapy, as per Appendix A on this form.

### Confidentiality

All personal information gathered by the therapist during the provision of the service will remain confidential and secure except when:

1. It is subpoenaed by a court; or
2. It is identified that a child, young person or others are at risk of harm or experiencing harm; or
3. Failure to disclose the information would place you or another person at risk; or
4. Your prior approval has been obtained to:
  - provide a written report to another professional or agency; or
  - discuss the material with another person.

Name of Client: \_\_\_\_\_

DOB: \_\_\_\_\_ Telephone No: \_\_\_\_\_

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

Name of parent / guardian / carer if applicable: \_\_\_\_\_

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

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## APPENDIX A

### Consent to Disclose and Receive Personal Client Information

I, .....  
(Name of Client)

I, .....  
(Name of parent, carer or guardian)

of.....  
(Client's address)

I give my consent to Footsteps Therapy to disclose and receive my personal information with the professionals and / or organisations I have listed below:-

Professional's' name or name of specific organisation	The information is to be shared for the purpose of:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client's signature)

Therapist Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Therapist's signature)