MICHELLE BARRATT PSYCHOLOGY

Practice Specialising in Children, Adolescence, Adult and Couples Therapy
B. Psych Sc., B. Psych Sc. (Hons), M. Clinical Psych., AHPRA, MAPS
Provider Number: 4549328H (Toowong), 4549327X (Wynnum West)
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PRIVATE AND CONFIDENTIAL

STRICTLY FOR THE INTENDED RECIPIENT ONLY.
IF YOU RECEIVE THIS REPORT AND ARE NOT THE RECIPIENT PLEASE RETURN TO SENDER IMMEDIATELY OR SHRED.
NOT PERMITTED TO BE SHARED OR COPIED.

- RELEASE OF CONFIDENTIALITY FORM - FOR PSYCHOLOGISTS AND OTHER ALLIED PRACTITIONERS as Independent Contractors

Release of Confidentiality from Client:

Please review the ***information below*** which will cover a myriad of circumstances for the clients from this Practice (Michelle Barratt Psychology) will see. Please sign below (Page 2) indicating ***your full consent that your nominated Practitioner named on Page 2, can obtain this information***. All endeavors will be made to maintain your and or your child's Privacy.

Psychological Service and Counseling
As part of providing a psychological service and counseling to you or your child, Michelle Barratt Psychology will need to contact and collect personal information about you or your child from a third party/s. This information will be extremely relevant to understanding you or your child's current situation/case and will be a necessary part of the psychological assessment and treatment that will be conducted for you and or your child.

Fees
You will be charged a fee for the time it takes to collect this information and for any assessments or reports that are required to be put together for presentation of the material or for any attendance in court or other persons to present said reports/material in court or in session to you.

Confidentiality
All personal information gathered by the psychologist / counselor during the provision of the psychological / counseling service will remain confidential and secure except when:

1. It is subpoenaed by a court/judge, or
2. Failure to disclose the information would place you or another person at risk, or
3. Your prior approval has been obtained to:

a) Provide a written report/letter/affidavit to another professional or agency/institution/school/medical service/court, e.g. A GP, Psychiatrist, Pediatrician, school, hospital, court, a lawyer, insurance provider or a health care treatment provider; or
b) Discuss the material with another person, e.g. A parent or teacher, policeman, a GP, a lawyer, medical officer, guidance office, family, friends,psychiatrists, pediatricians, psychologists, etc,
c) Your treating psychologist provides a psychological/medical report/letter/affidavit/psychological report, or needs to speak or email your General Practitioner (GP) when not supported through the Medicare Better Access Scheme or through a Mental Health Care Plan.

Access
You may access the assessment or report material recorded in your file upon request, subject to the exceptions in the Australian National Privacy Principle 6.

1. **Please USE THIS FORM TO nominate the Health Provider you provide consent to, to contact 3rd party's to provide collateral information to, to support your and or your child's psychological support.**
2. **Please also sign below your full acknowledgement and acceptance of your 'consent for your Treating Practitioner' to contact the relevant person/s listed below (in 1., 2., and 3., if required) to provide collateral information to support your Psychological Treatment; particularly when the following situations occur, but not only bound by:**

a) Your treating psychologist or counselor needs to provide a Psychological Report/Medical Report/Letter to GP or other treating Specialist, or needs to speak or email your General Practitioner (GP) or other particular persons to gain 'collateral information' to support your Mental Health Care and Treatment Plan.

b) Your consent is especially required when not supported through the Medicare Better Access Scheme or through a Mental Health Care Plan. Even if not under this umbrella of support or health care, your consent is still required.

c) That you provide full consent for your or your child's (Up to 18 years of age) treating psychologist or counselor to contact the person/'s listed below:

PRINT NAME OF PRACTITIONER YOU PROVIDE CONSENT FOR TO CONTACT 3RD PARTY/S:

_____ Date: _____

THE PERSON/S YOU WOULD LIKE YOUR TREATING PRACTITIONER TO CONTACT:

1. Name of Person to be Contacted: _____

Place of Work & Position Of Employment: _____

Email/Mobile/Telephone: _____

2. Name of Person to be Contacted: _____

Place of Work & Position Of Employment: _____

Email/Mobile/Telephone: _____

3. Name of Person to be Contacted: _____

Place of Work & Position Of Employment: _____

Email/Mobile/Telephone: _____

PLEASE PROVIDE YOUR NAME & SIGNATURE BELOW STATING YOU ARE 'PROVIDING SIGNED CONSENT' FOR THE NOMINIATED PSYCHOLOGIST TO CONTACT 3RD PARTY/S & FOR THE RELEASE OF CONFIDENTIALITY BEING ACKNOWLEDGED.

Name Of Client: (PRINT NAME): _____ DOB: _____

Signature: _____ DATE: _____

NAME & SIGNATURE OF PSYCHOLOGIST/ALLIED HEALTH PRACTITIONER YOU AGREE TO CONTACT NAMED PERSONS ABOVE:

Name of Psychologist/Allied Health Practitioner (PRINT NAME): _____

Signature: _____ DATE: _____