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**CONSENT TO PROFESSIONAL USE OF**

**CLINICAL RECORD DATA AND AUDIO VISUAL RECORDINGS OF SERVICE**

By checking items that are acceptable to me and by signing below, I (or we) are agreeing to the following professional use my own, my child’s or my ward’s information associated with my counselling services with Dr. Amanda Bell, RSW, and Associates.

I am agreeable to my own or my child’s or ward’s clinician making non-identifying digital photographs of therapeutic work completed during sessions for use in:

\_\_\_\_\_\_ consultation with a clinical supervisor within or outside of this setting

\_\_\_\_\_\_ in-service training of other professionals or interns in this setting

\_\_\_\_\_\_ scientific presentations, research or publications as long as the data are presented anonymously and in a manner that would completely protect my own or my child’s or ward’s identity.

I am agreeable to my own or my child or ward’s clinician using non-identifying information from my own or my child/ward’s written clinical record for:

\_\_\_\_\_\_ consultation with an expert within or outside of this setting

\_\_\_\_\_\_ in-service training of other professionals or interns in this setting

\_\_\_\_\_\_ scientific presentations or publications as long as the data are presented in grouped statistical form, so that no individual

information is reported, or individual data are presented anonymously and in a manner that would completely protect my identity.

I am agreeable to my own or my child’s or ward’s clinician emailing me to:

\_\_\_\_\_\_ schedule appointments and respond to my emails reflecting questions I may have about my treatment

and am aware that while every effort will be made to ensure that communication remains confidential, I also understand that there is possibility that email communication could be misdirected.

I am agreeable to the office administrator at Dr. Amanda Bell RSW, and Associates having access to:

\_\_\_\_\_ my own, my child’s or my ward’s demographic information and dates of therapy for administrative purposes and understand I also understand that the office administrator at Dr. Amanda Bell RSW, and Associates has signed a Confidentiality Agreement and is also legally bound to maintain confidentiality of client records.

I understand that anyone who hears or view material from my own or my child’s or ward’s clinical record is a professional and is ethically obligated to protect my confidentiality just as rigorously as my clinician is bound.

It has been explained to me that I may refuse consent to allow any of the above uses of my counselling information without impacting services offered to me by Dr. Amanda Bell, RSW and Associates:

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Client’s Signature Date

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Print Name

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Client’s Signature Date

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Child Client over 12yrs Signature Date

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