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370 Queens Ave, Suite 100

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**WAIVER OF RIGHT TO CHILD’S RECORDS**

I hereby waive my right as parent/guardian to obtain information and/or copies of any records from Dr. Amanda Bell, RSW and Associates relating to the treatment and/or counselling of my child or ward

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (child or ward’s name) (day/month/year)

I acknowledge and understand that Dr. Amanda Bell, RSW and Associates will not provide me direct access to the file or segments of the file if, in their professional opinion, to do so would be detrimental to my child or ward’s well-being. If access is refused I understand, I will be advised of the reason for refusing so that we may discuss it.

I have been informed that Dr. Amanda Bell, RSW and Associates recognize the importance of parents and guardians being active partners in treatment and of their being informed of their child’s or ward’s treatment progress. We also respect children’s right to privacy of information. Therefore, we share information in ways that strive to balance these rights. These include the child or ward being made aware of the information that will be verbally shared or written and/or their being present during the sharing of information where deemed appropriate.

I have been informed that I have a right to ask any and all questions I may have about my child’s or ward’s treatment with Dr. Amanda Bell, RSW and Associates.

I hereby release Dr. Amanda Bell, RSW and Associates from any and all liability for refusing to disclose my child’s records if the refusal is made in good faith.

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Signature of Parent/Guardian Date

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 Therapist Signature Date