Mental Health Counselling: Consent to Services
(CHILD under 16 yrs old)

Consent to Services:
This form is to document that I/we, _____
(parent/legal guardian), give consent for a Mental Health Counsellor, with Niagara
North Family Health Team, to provide counselling services to my/our child:

Name of Child: _____**Date of Birth**: _____ **Age:** ____

Confidentiality Information:
I understand that the information my child provides to the counsellor is private and
confidential, within the scope of treatment of this medical practice, which operates
under a *Circle of Care* model. *Circle of Care* includes individuals, within Niagara
North Family Health Team, who provide health-related and administrative services
on my child's behalf. I understand the counsellor's notes are a part of my child's
medical record. Confidentiality is respected at all times. I understand that no
information will be communicated , directly or indirectly, to a third party without
my informed and written consent.

Exceptions to confidentiality include legal and/or ethical obligations to:
- Inform a potential victim-of-violence regarding a patient's intention to harm
- Inform an appropriate family member, health-care professional, or police (if necessary) of a patient's intention to end his or her life
- Release a patient's file if there is a court order to do so
- Inform the Children's Aid Society if there is a suspicion of a child being at risk or in need of protection due to neglect, or physical, sexual or emotional abuse
- Report a health professional who has sexually abused a patient
- Share information with a Clinical Supervisor and/or with the counsellor's regulatory college for supervision and/or auditing purposes

Terms of Counselling:

1. I understand that if I need to cancel or reschedule my child's session, then I am requested (if possible) to give 48-hour notice.
2. I understand that if my child does not show for 3 scheduled sessions, then together, with his/her counsellor, we will revisit the efficacy of services.

Informed Consent:

I, _____ understand and
consent to the counselling conditions for my child, as outlined above, and indicate
this with my signature below:

Patient's Signature: _____ Date: _____

Counsellor's Signature: _____ Date: _____