IMPORTANT

Australian Government
Open Arms - Veterans & Families Counselling

# Open Arms Parental/Legal Guardian Consent to Exchange Personal Information

**Note:**

- A new Client Consent Form is required for each Episode of Care.
- A client's consent form lapses when an Episode of Care is closed. Consent is valid for the current Episode ONLY.
- A new Client Consent Form must be completed if changes are required by the client during an Episode of Care.
- Consent can be withdrawn by a client at any time.
- The client must be given a copy of the signed Client Consent Form, if requested.
- The clinician is to scan the signed form and attach it to the client's electronic record.
- Information collected will be used by Open Arms for the purpose of providing counselling services to you.

**Privacy notice**

- Information collected on this form is for the purpose of providing Open Arms counselling services to you. Such services may include individual, couple and family counselling; after hours crisis telephone counselling, case management services, group programs and a range of other focussed programs and other support. Further information on these services can be found at www.openarms.gov.au
- Open Arms services are provided pursuant to section 92 of the *Veterans' Entitlements Act 1986*.
- Information collected on the form may be disclosed to persons and/or organisations identified by you on this form or otherwise as authorised by the *Privacy Act 1988*.
- You are able to withdraw your consent to the disclosure of your information to the below nominated persons/organisations at anytime.

I _____ *(parent/guardian name)*

of _____ *(full address)*

in relation to my child, _____ *(child's name)*

for the period of the episode of care commencing on ____/____/____ *(date)*

give Open Arms or their appointed Contract Service Provider my consent to obtain from or provide information to the following stakeholders and health care professionals/agencies:

| | *Name* | *Phone No.* | *Regarding (specify any limits to information that can be shared)* |
|---|---|---|---|
| **Next of kin** | | | |
| **Psychiatrist** | | | |
| **GP/MO** | | | |
| **Allied Health** | | | |
| **Other/s** *(specify role)* | | | |
| | | | |
| | | | |

I understand that I can withdraw my consent at any time.

**Parent/guardian signature** _____ Date ____/____/____

**Clinician signature** _____ Date ____/____/____

NB: The clinician must scan the signed form and attach it to the client's electronic record

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