**TPS Privacy & Consent Form**

Your privacy is important. As your mental health provider, I obey all state and national laws on confidentiality and privacy, including the *Privacy Act* 1988 (Commonwealth) and the *Health Records Act* 2001 (Victoria).

**Confidentiality**

It is against the law for me to give information about you to anyone except in special situations.

All your personal information will remain private and confidential and will not be shared, except when:

* You have given written consent to share your information with another person or agency for health care reasons; or
* The law requires or allows your information to be shared; or
* I reasonably believe that sharing your information is needed to lessen or stop:
  + a serious threat to someone’s life, health or safety in the near future; or
  + a serious threat to public health or public safety.

**Sharing your information**

I keep notes of our sessions, but **only with your consent** will I share relevant/specific information with your doctor or person who referred you, or with another health care worker who you see.

**Storage and disposal of records**

All your records are kept in a secure place. When they aren’t needed anymore, they are disposed of the way the law requires.

**Referral Expiry**

Please be aware TPS is short term funding counselling support for clients with a health care card. The referral from your GP expires after 12months. You will need to get a new referral after this date should further counselling be required.

**I am:**

16 years or over

Under 16 years, and my parent/carer has not signed this form

Under 16 years, and my parent/carer has signed and agreed with this form

I, ………………………………………………………………….. (*Full name)*

OR

.................................................................................................. (*Parent/carer’s full name*)

**I have read this form and:**

* I understand what it means.
* I give consent for my counsellor to speak to my doctor or person who referred me, and to share relevant/specific information from our sessions.
* I give consent for my counsellor to speak to .................................................................. and to send information as described above.

**Signature………………………………………………………………..… Date ….../….../20…......**

**I am happy for my mental health provider to contact the following person in an emergency, when I can’t be reached.**

**In an emergency, please call**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On phone number(s)** (landline &/or mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_