**Confidentiality Agreement and Research Consent**

**Child and Adolescent Counselling & Psychotherapy Service**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client File Reference No:** | **Client’s first name** | **Known as** | **Date of Birth** |
|  |  |  | **/ /** |

This form has 5 parts. Part 1 is for a client (Child or Adolescent) and the other parts are for the clients’ parents or legal guardians.

**Part 1;** Asks for agreement to:

* Share information about you in certain situatons (described below) with your parents or legal guardians if we are concerned about you.

**Parts; 2,3,4** and **5** are mainly for parents and legal guardians but the client can read these parts too.

**What you have to do**

Please read this form carefully and ask the therapist to explain anything you’re not sure of. If you agree with the points in it, please indicate your agreement by ticking 'Yes’ when asked and sign and date the form on page 2 if you are under 18.

If you are a parent or legal guardian, you will need to agree with the points on page 2,4 &5 and sign on page 6.

**Part 1: Client (Child or Adolescent)**

**Confidentiality and its Limits**

We believe therapy works best when you feel comfortable talking with your therapist. Sometimes you might want to talk about things that you find it hard to talk to others about. You have the right to keep your therapy with Ballincollig Family Resource Centre confidential and private. Your privacy is important to us. However, there are some exceptions to keeping certain information confidential. It is important for you to understand these exceptions before starting therapy with Ballincollig Family Resource Centre Please read through these and ask your therapist if you have any questions.

**Limits to what we can keep confidential:**

* If you tell your therapist that you plan to harm yourself, we will need to share this information to protect you.
* If you tell your therapist that you plan to harm someone else, we will need to share this information to protect that person and you.
* If there are concerns for your safety as set out in law such as the Children First Guidance 2017 and Children’s First Act 2015.
* If there are child protection or abuse concerns, we must by law report these to relevant authorities.

**By signing below you are saying that you have read the information above and understand the limits to confidentiality. If you have any questions you can ask your therapist at any time.**

 *(please sign your name below)*

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_**

**(Under 18)**

**Part 2: Parents and Legal Guardians**

**Is the child or adolescent under 18 years of age at time of first appointment?**

**Yes No**

By law and under the National Guidance for the Protection and Welfare of Children, anyone under 18 years of age who wants to attend therapy must have the permission in writing of their parents or legal guardian. If a child is referred by a school, we must tell the school in writing that the child is attending Ballincollig Family Resource Centre.

If you agree with your child engaging in therapy sessions with Ballincollig Family Resource Centre please complete the details below.

**Do you consent to your child attending therapy with BFRC?**

**Yes No**

Ballincollig Family Resource Centre *would request that both parents are aware and in agreement of the child attending therapy at* BFRC.

**Part 3 Contact ICE and other Professionals**

**Contacting In Case of Emergency (ICE)**

**Do you give permission to** **Ballincollig Family Resource Centre** **to contact you?**

**Yes No**

**Contacting other Professionals and Service Providers**

 Ballincollig Family Resource Centre may need to consult with other professionals (such as your child’s GP or psychiatrist) or other services that the child attends about their care. This is to make sure they are receiving the best possible service for their needs.

**Do you give permission to** **Ballincollig Family Resource Centre** **to contact other health professionals and service providers involved in your child’s or ward’s care**?

**Yes No**

**Part 4: Research**

At Ballincollig Family Resource Centre we are contiually trying to improve the services we offer. By signing this form, you give us permission to contact you to invite you and your child to take part in research projects. You have the right to withdraw permission at any time and refuse any further involvement with Ballincollig Family Resource Centre.

**Do you consent to Ballincollig Family Resource Centre** **contacting you about future research projects?**

**Yes No**

**Part 5: Evaluation**

When your child finishes therapy, we would like to give you a short feedback & evaluation form for your child to complete. This form is about their experience of using the counselling & psychotherapy service at BFRC. The therapist will provide you with a stamped addressed envelope to you so that you can post the evaluation form back to Ballincollig Family Resource Centre when you finish therapy. All feedback given on this form is anonymous and confidential and is used for the purpose of service improvement.

**Do you give permisison to Ballincollig Family Resource Centre** **to give you an evaluation form for your child to complete after they finish their therapy?**

 **Yes No**

**Parents / Legal Guardian Signature :**

**I have read and discussed the above information with the therapist. I understand the nature and limits of confidentiality.**

**Dual Consent**

**Name Relationship to Client Signature**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_­\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_­\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_

In the case of a solo guardianship, I confirm that I am the sole guardian for this child and do not require a second signature

**Solo Guardianship consent**

**Name Relationship to Client Signature**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_­\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_