**UNIVERSITY OF WATERLOO**

**CENTRE FOR MENTAL HEALTH RESEARCH & TREATMENT (CMHRT)**

# CONSENT FOR TREATMENT SERVICES

I/My child have/has been offered psychological treatment at the Centre for Mental Health Research and Treatment (CMHRT) at the University of Waterloo. My clinician has provided me with an overview of treatment procedures and services that she/he will be providing and I consent to the treatment. My clinician has talked about the potential risks and benefits of the treatment services. I also understand that I may terminate service at any time without any negative impact.

I understand that this is a teaching facility and that clinical services are provided by Clinical Psychology Doctoral students and residents under the supervision of Registered Psychologists. I also understand that my therapy sessions will be observed and/or recorded as outlined in the *“Centre for Mental Health Research and Treatment (CMHRT) Letter of Information.*” I also understand that de-identified information may be discussed at case conferences to improve the services provided and to facilitate student learning. I also understand that de-identified information from my file may be used in research or evaluation of the services provided by the CMHRT. I also understand that specific types of de-identified and personally identifying information gathered during my treatment at the CMHR may be used for research purposes, if I have opted to provide consent for such use by checking the appropriate checkboxes in the “*CMHRT Consent for Research Participation*.”

A member of the CMHRT staff has discussed with me policies regarding the nature of the personal health information that will be collected, as well as its privacy, and I understand the limits on that privacy. I am aware that I may access this file and request a correction of information that is inaccurate or incomplete except in limited circumstances such as where I might access information about another person or copies of some standardized psychological tests. I have had the opportunity to ask questions and seek clarification of all information provided by my clinician.

My signature indicates that I have reviewed the information, had an opportunity to ask questions, and indicates that I understand and agree to this statement regarding the privacy and confidentiality of personal health information.

Authorizing Signature\* Name of Client (if different from authorizer)

Printed Name Client’s Date of Birth

Relationship to Client Date

\* “Authorizing signature” refers to the client or, when the client is too young to provide consent, the client’s parent or legal guardian