Consent to Share Information for Drug and Alcohol Counselling

Client Information:

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____

Treatment Provider Information:

- Provider Name: Kelly-Ann Faulkner
- Facility Name: AOD Counselling
- Phone Number: 0452 420 367

Purpose of Sharing Information:

This document grants permission for the exchange of information related to my treatment for drug and alcohol counselling between my treatment provider and specified parties. This sharing aims to enhance the coordination of care, support recovery efforts, and provide comprehensive services.

Parties Authorised to Receive Information:

I consent to share my treatment information with the following individuals or organizations:

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

Nature of Information to be Shared:

The information to be shared may include, but is not limited to:

- Assessment and treatment plans

- Progress notes

- Referral information

- Medication management details

Confidentiality:

I understand that all shared information will remain confidential and will only be used for the purposes outlined in this document. I am aware of my rights concerning confidentiality and understand that my information will not be disclosed without my written consent, except as required by law such as instances of abuse, harm to self or others, or a court order.

Consent Duration:

This consent is valid for a period of 12 months from the date of signing, with the option to revoke consent at any time in writing.

Client Consent:

I have read and understood the information provided above. I hereby consent to the sharing of my treatment information as outlined in this document.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____