



### **Consent for Psychology Services (Assessment/Consultation/Intervention)**

I/We, the undersigned, being the parents/guardians of \_\_\_\_\_, give consent for psychology services (assessment/consultation/intervention). These services will be provided by Angela Romaine, BScH, MSc., Registered Psychologist. I/We acknowledge and understand that:

- I/we have been informed of the nature of these services.
- that consent to this service is voluntary and can be withdrawn at any time.
- all services are confidential.
- there may be potential risks and benefits with assessment and classroom services (e.g., missed classroom time, changes in skill development).
- there are limits of confidentiality outlined here, which have been explained to me.

### **Limits of Confidentiality**

Information collected from you or your child by High Integrity Psychology is confidential EXCEPT if you disclose information that indicates possible abuse of a minor or if the minor, in the process of being assessed or treated, reveals potential abuse or possible harm to themselves or others.

If subpoenaed by a court of law, all information in your child's file must be provided to the court.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date