wcb Workers' Compensation Board – Alberta

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HC-965

PSYCHOLOGY SERVICES

Family Member Counselling Authorization and Consent

I, _____, authorize _____
(name of client) (name of Psychologist/Social Worker)

to provide me with psychological treatment services. I understand and agree that:

1. I may at any time decline or discontinue treatment with the psychologist/social worker. If this occurs, I will advise the provider I no longer wish to attend counselling.
2. The use of any recording devices without the signed consent of both myself and the psychologist/social worker is prohibited. Any violation may result in the termination of the services.
3. The psychologist/social worker will send brief, limited reporting as needed to the WCB that summarizes treatment goals and progress when I attend therapy jointly with the injured worker as a couple or family unit. I can request a copy of my report from the provider, who will determine appropriate release.
4. Copies of treatment extension requests will be places on in a Psychology File within the Health Information Unit at Millard Health Centre and will not be placed on the injured worker's claim file.
5. I understand that the information related to my treatment may be used for research regarding program effectiveness. I understand that the intent of the use of this information is to improve psychological services provided by the WCB.

The information collected by this psychologist/social worker is confidential and protected under the Protection of Privacy Act, Health Information Act, and Workers' Compensation Act. This collection of personal information is in compliance with Section 4 of the Protection of Privacy Act, Section 20(a) of the Health Information Act, and is collected under the authority of the Workers' Compensation Act.

By signing this document below, I declare that I have read it, understand, and agree to the provision of psychological services on the above basis.

Dated at _____ , Alberta, this day of _____ , 20 ___
(city/town)

Witness signature | Client signature

- OR -

If client is unable to sign or is a minor, signature of parent, guardian or legally authorized representative is acceptable.
Please include your relationship to client.

Witness name – PRINTED | Client name - PRINTED

FOR USE WHEN INTERPRETER INVOLVED:

I have interpreted the contents of this document to the above client, and I am satisfied that the client understands the content, purpose, and nature of this document and has accordingly agreed to it.

Witness signature | Interpreter signature

Witness name - PRINTED | Interpreter name - PRINTED