



London Middlesex Clinical Supervision & Addiction Services (LMCAAS)

CONSENT FOR CLINICAL SUPERVISION SERVICES

Name _____ Address _____ DOB _____

Clinical Supervision services provided by a LMCAAS Clinical Supervisor is a service provided by the London Middlesex Clinical Supervision and Addiction Services (LMCAAS). The LMCAAS Clinical Supervision Service is carried out by a registered social worker, a registered social service worker and/or psychotherapist.

- Risk and benefits: I understand that there are risk and benefits while participating in the therapeutic services offered by LMCAAS. I understand that by participating in these services may involve my recalling of unpleasant memories and events and may cause strong emotional feelings which may induce painful, stressful and unpleasant feelings. I understand that these feelings can impact my relationships with others. However, I also understand the potential benefits I may garner to increase stress tolerance, increased self awareness and self determination. As well I understand that this discomfort may also lead to growth and the developed of greater resiliency and self awareness.
- Confidentiality: I understand that all information disclosed during my involvement with LMCAAS Clinical Supervisor is confidential and may not be revealed to anyone without my permission. I further understand that confidentiality **cannot** be maintained by the LMCAAS Clinical Supervisor when:
1. I present a serious danger to myself or to a client
 2. When there is an indication of abuse, confirmed or suspected (past or present).
 3. A court order is made for information and/or clinical records about my Clinical Supervision]
- Professional Regulations and Clinical Records: I understand that members of LMCAAS are obligated to keep a written record of our meetings, which includes general information of what we have discussed during our sessions. These records are securely stored and will be made available to me upon my request. I understand that members of LMCAAS may disclose information about my Clinical Supervision sessions to his or her professional colleagues or clinical supervisor, my field supervisor and/or future employer. These consultations can help my Clinical Supervisor to understand me more fully. I understand that the clinical records kept by Social Workers, Psychotherapists and are subject to review by their respective regulatory and/or licensing bodies. This is done in order to ensure client rights are being protected and appropriate levels of professional standards are being maintained.

This consent to Clinical Supervision shall remain in effect for one year after the date signed below.

Sign: _____ Date: _____ Witness: _____