CENTRE AGAINST SEXUAL ASSAULT CENTRAL VICTORIA

IRIS Number: _____

Consent to Disclose / Limited Confidentiality

I, _____ on behalf of _____

consent and understand that all information shared with Centre Against Sexual Assault Central Victoria will be kept confidential, however where a Counsellor Advocate is concerned about my safety and/or the safety of family members or others, a Counsellor Advocate may contact relevant services **without my consent** and provide information relevant to the safety issues only.

Your de-identified case notes may be subject to review by an External Accreditation Agency.

I understand that limited confidentiality applies:

- During case discussions with staff within CASACV and Clinical Supervisor.
- Where there is a risk of me being at risk or risk to others.

Services that may be contacted in this regard include:

- Police
- Child Protection
- Local Doctor
- School
- Community Health Nurse
- Mental Health Services / Hospital
- Family members (where appropriate)

I agree to Counsellor Advocates contacting the following agencies/individuals. Any additional agencies/individuals will require signing of further release forms.

Date	Agency	Contact name	Position	Phone Number

Signed: _____ Dated: _____