

## Firle B therapies accessible privacy consent form

|                  |  |
|------------------|--|
| Your Name        |  |
| Date of Birth    |  |
| Therapist Name   |  |
| Date read/signed |  |

Do you agree too?



Firle B Therapies gathering **personal** and **health information** for my treatment

Yes  No 

Making a **conversation video** with my **chosen communication partner** for **Firle B Therapies**



Yes  No 

My **personal** (email, address, mobile) **health** and **conversation data** being kept in **WriteUpp** for **8 years** after I **stop working** with **Firle B therapies**

Yes  No 



My **conversation videos** being **deleted immediately** on **discharge**

Yes  No 



Client(s) signatures: \_\_\_\_\_ & \_\_\_\_\_

Date signed: \_\_\_\_\_ & \_\_\_\_\_