**SAMPLE CONSENT FORM**

Psychedelic Harm Reduction and Integration

**Participation**

I understand that psychedelic harm reduction and integration are brief interventions and are not long-term therapies, therefore my therapist does not assume responsibility for my care on an ongoing basis. As such, I understand and confirm that:

* This form is for psychedelic harm reduction and integration which is one treatment approach. There are many other treatment and therapy options that could benefit the client in conjunction with this treatment.
* I understand that the therapist is not promoting or condoning the use of psychedelics. The intention of psychedelic harm reduction and integration services is to mitigate adverse effects and maximize benefits. The choice of using psychedelics or not is the responsibility and choice of the client.
* I am not suffering from any medical or psychiatric condition that could be construed as a contraindication for psychedelics and psychedelic harm reduction and integration.
* I have been fully informed of and have had the opportunity to ask questions about the known potential adverse effects of psychedelics and psychedelic harm reduction and integration.
* I assume responsibility for having access to a primary care provider and/or a mental health or other social supports prior to, for the duration of, and following this program. In the case of a crisis or emergency, I will go to the nearest emergency room. I am responsible for understanding how to access emergency services in my physical location.
* I understand that the therapist will maintain my records for the period of time required by their regulatory college, and that electronic communications may be included as part of this client record.
* I understand that my physical location at the time of the medicine and other sessions, email, or telephone communication may bring specific confidentiality requirements and related legislation / legal requirements.
* I confirm that if online, I will always be logging into program sessions from the city / town / community indicated as part of my address on the assessment form. If I need to log in from a different province / state / country, I accept the responsibility of letting the therapist know in advance of the session.
* I acknowledge that [your organization] is not responsible for my healthcare and has no liability around my healthcare.

*Please note that you must consent to the above to participate in psychedelic harm reduction and integration therapy.*

□ I Consent Client Initials: \_\_\_\_\_

**Confidentiality**

**Limits to Confidentiality**

[ORGANIZATION] acknowledges that patient confidentiality and privacy is of high priority and will uphold this to the extent possible. All communications between you and the healthcare provider(s) facilitating your psychedelic harm reduction and integration sessions are confidential, except actions or intent that fall outside these limits. The circumstances in which a healthcare provider is required by law to breach your confidentiality include:

1. You express risk of harm to self and/or others
2. You are at risk of harming a child (through acts of omission or commission such as neglect or abuse)
3. You are at risk driving (e.g. intoxicated)
4. You report being abused by a physician or registered healthcare provider to another registered healthcare provider

I understand that under the above circumstances, it is mandatory that the healthcare provider take the appropriate action as outlined if they are required by law to do so.

□ I Consent Client Initials: \_\_\_\_\_

**Electronic Communication**

I consent to communicate with the care provider facilitating my treatment via unencrypted email (e.g. gmail). I understand that unencrypted email may not be secure for personal health information. It may be accessed by others, accidentally forwarded, or exist indefinitely. I agree not to communicate confidential information about myself or any other person using unencrypted email. I further understand that I should not communicate time sensitive or emergency information via unencrypted email.

□ I Consent Client Initials: \_\_\_\_\_

**Video Conferencing**

Video conferencing reduces the ability to maintain confidentiality. I clearly understand that security is not guaranteed in a video conferencing platform. Under those circumstances, I will not hold [ORGANIZATION] nor the healthcare professional facilitating my treatment liable for such a breach. I also understand that video conferencing should not be used in the event of an emergency or anything else of a time sensitive nature.

□ I Understand Client Initials: \_\_\_\_\_

**Statement of Understanding**

I have been informed of and understand the conditions and procedures as outlined above and accept the services with full knowledge and understanding of the relevant conditions.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for your time in completing this consent form.**