Permission statement

Name
Address
Date of birth
Sex
Telephone number
Social security number (BSN)

Practice	iMindU
Name of responsible practitioner	M.J. van Hoof

Date permission given

- ☐ Patient gives permission for telephone consultation with patient's family doctor to take place, both to provide and to request information.
- ☐ Patient gives permission for a letter or indicative report, treatment plan, etc., to be sent to patient's family doctor.
- ☐ Patient gives permission for a closure letter to be sent to patient's family doctor.
- ☐ Patient gives permission for contact and consultation to take place with school or remedial teacher (in the case of a child), both to request information and, in consultation with patient/patient's legal representative, to provide information.
- ☐ Patient gives permission for contact and consultation to take place with practitioners previously involved with patient, both to request information and to provide information, in consultation with patient/patient's legal representative, namely:

    - Medical specialists [name, address, telephone number]…….

    - Youth healthcare professionals [name, address, telephone number]…….

    - Child healthcare clinic, school doctor [name, address, telephone number]…….

    - Psychologists, providers of basic mental healthcare [name, address, telephone number]

- Paramedics [name, address, telephone number]

☐ Patient gives permission for audio-visual recordings to be made for diagnostic and therapeutic purposes relating to the scoring, processing or supervision of the treatment. These recordings will be stored securely. Once the purpose for which the recordings were made has been fulfilled, the audio-visual recordings will be deleted.

Seen and approved by:

Practitioner name	Patient name	Representative(s) name(s) (where applicable) 1:
		2:
Leiden	Place:	Place:
Date:	Date:	Date:
		Signature(s):
Signature:	Signature:	1:
		2: