

# Newham Music Trust

# Soundscape

Wakefield Street

East Ham

London E6 1NG

Tel: 020 8472 9895

Fax: 020 8471 0495

E-mail: soundscape@newham-music.org.uk

[www.newham-music.org.uk](http://www.newham-music.org.uk)

**Music Imagery & Music Therapy Consent Confirmation Form**

**During the course of therapy the music therapist and music imagery therapist may wish to use audio/video to record sessions and have access to medical records / organisational service user’s file / school pupil file if appropriate.**

|  |  |  |
| --- | --- | --- |
| **Purpose of recording** | * Assessing a client’s needs and suitability to receive music therapy or music imagery therapy * Planning, monitoring and evaluating and the work * Discussion with a supervisor * Consultation with other professionals involved in the care / support of the client | |
|  | Tick this box if you do not wish recordings to be used for professional presentations. |
| **Confidentiality Criteria** | * All recordings are confidential and will be stored securely for a period of up to five years after finishing therapy and then destroyed. If they are required for uses other than those agreed at the time of signing this form, further consent will be sought. * In some cases only a proportion of the sessions will be recorded and/or only a proportion of the recordings kept after they have been viewed. | |
| **Purpose of accessing medical records / organisational service user’s file / school pupil file** | To gain a fuller understanding of the client, the music therapist/music imagery therapist may need to consult medical practitioners / his/her pupil file, if appropriate. | |
| **Confidentiality Criteria** | Any written information obtained will be kept securely. | |
| **Home Address** |  | |
| **Date of Birth** |  | |
| **Name of person who gives consent** |  | |
| **Signature to confirm** | I agree that audio / video recordings of music therapy sessions for the above may be made and used for the purposes of assessment, evaluation, supervision and multidisciplinary consultation.  Signature……………………………………………………………………………………… | |

Date……………………………………………………….

#### PLEASE RETURN TO: Motoko Hayata or Dr. John Strange at uumemt@gmail.com