***Confidentiality Document***

**Child Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAPT Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned agree that this meeting and discussion is confidential and only for the purpose of service coordination and treatment planning.

|  |  |
| --- | --- |
| **Signature**  | **Agency**  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |