Living Well Psychology & Support

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PART A: Consent to Release Information

I agree for _____ (Psychologist) to release information about my condition and treatment to:

□ Doctor □ Paediatrician □ Psychiatrist □ Psychologist

□ School □ Family Member □ Other: _____

Name: _____

Address: _____

_____

Phone: _____

PART B: Request For Information

I agree for _____ (Third Party) to release all relevant information about my condition and treatment to _____ (Psychologist) at Living Well Psychology.

Details of any specific Information requested:

_____

_____

PART C: Client Information

Client Name: _____

Date of Birth: _____ /_____ / _____

If a minor Parent/Guardian name: _____

Signature: _____

Date: _____ /_____ / _____