



Living Well

Psychology & Support

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Consent to Release Information

I agree for Living Well Psychology & Support to release information to:

Relationship: _____

☐ Appointment Information

Name: _____

☐ Therapy Information

Organisation: _____

Phone / email : _____

Consent expiry: _____

Relationship: _____

☐ Appointment Information

Name: _____

☐ Therapy Information

Organisation: _____

Phone / email: _____

Consent expiry: _____

Relationship: _____

☐ Appointment Information

Name: _____

☐ Therapy Information

Organisation: _____

Phone / email: _____

Consent expiry: _____

Client Name: _____

Date of Birth: ____ / ____ / ____

Nominee/Parent/Guardian name: _____

Signature: _____

Date: ____ / ____ / ____