GEORGE STREET PSYCHOLOGY

AUTHORISATION TO USE AND RELEASE HEALTH INFORMATION

NAME: _____ DATE OF BIRTH: _____

I authorise the release of confidential information between George Street Psychology, and:

Name: _____

Address: _____

Phone: _____

Please provide the following information (initial those requested)

_____ Appointment Dates and Times of service

_____ Summary letter

_____ Other

Purpose of Exchange: _____

This release will be in effect for six months from the date of Authorisation and may be revoked at any time. The cancellation will not affect any information released before the cancellation.

I have read and understand the terms of this Authorisation and I hereby, knowingly and voluntarily, authorise George Street Psychology to use or disclose health information in the manner described above.

_____

Client Signature Date

_____

Parent/Legal Guardian Signature (if client is 13 years of age or younger) Date

To those receiving information under this authorisation:

This information is protected by State and Federal Law. You are not authorised to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorised by other laws.