AUTHORISATION FOR THE RELEASE OF INFORMATION

LifeAssist.

engaging people

Name of client:

_____

Organisation of client:

_____

Contact details of the client:

_____

Name of therapist:

_____

Contact details of the therapist:

_____

I, _____ hereby agree that I fully understand the implications of disclosure, and that the implications have been discussed with me. In line with this, I hereby give full permission to LIFEASSIST and the clinician(s) providing services for LIFEASSIST to:

DISCLOSE / PROVIDE INFORMATION TO: (name of person to who the information must be provided to)	
OBTAIN INFORMATION FROM (name of person from whom the information must be obtained)	

PLEASE SPECIFY THE INFORMATION THAT YOU WANT DISCLOSED OR OBTAINED:	

THIS INFORMATION MAY BE OBTAINED/PROVIDED BY MEANS OF: (please provide relevant contact details)	
VERBALLY:	
IN WRITING:	
EMAIL:	

THIS CONSENT IS ONLY VALID FOR SIX MONTHS AND MAY BE REVOKED AT ANY TIME.

_____ _____

Signature of the client Signature of the therapist