Authorisation for the Relase of Information

Emotional Financial Physical Trauma HIV Legal

Name: Contact details:

Name of therapist: Contact details:

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 whom the information must be provided to)

OBTAIN INFORMATION FROM:
(name of person to 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:

SIGNED:
Date:

SIGNED (THERAPIST):
Date:

Please call the LifeAssist Care Centre **0800 NTHUSE (684873)** if you have any questions and to inform us of this Authorisation for the Release of Information.

EMAIL the completed form to help@lifeassist.co.za (If you cannot use a digital signature, then please print, scan and return via email).