Authorisation to Disclose Information

I, undersigned, _____
First and last name

Residing at _____
Home Address

_____ _____
Email Address Phone Number

As _____
Person receiving services, parent(s), legal representative

Authorise _____
Name of the organisation and/or mental health professional

to disclose to _____
Name of the organisation and/or mental health professional

_____ _____
Email Address Phone Number

The following information:

☐ Assessment report	☐ Progress notes
☐ Summary report	☐ Other: _____

For treatment or services received within the following period:

_____
Insert dates

And regarding the information contained in the file of the following person:

Name: _____

Date of Birth:_____

Address: _____

This authorisation is valid for a period of _____ days from the date of signature of this document.

To revoke this authorisation, please send a written request to the concerned mental health professional.

_____ _____
Signature of authorised person Date

_____ _____
Witness signature Date