Tranquil Minds

Counselling & Psychotherapy

Authorisation for Release of Information

1. Client's Name:____DOB:________________

2. Information to be released:
   - ☐ Summary of treatment to date
   - ☐ Report
   - ☐ Other: ____

3. Purpose of Disclosure
   - ☐ Coordination of Care
   - ☐ Other:____

4. Persons authorised to make Disclosure:

   ____

5. Person authorised to receive Disclosure:

   ____

6. Method of Disclosure
   - ☐ Written: ____
   - ☐ Verbal:____
   - ☐ Electronic:____

7. Today's date:______________________________Authorisation to expire on: ______________

I understand that my health information is protected by law. I authorise the release of my confidential health information as indicated above. I understand that my consent is voluntary, and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorisation. Should I choose to revoke this authorisation I will state this in writing.

Signature of Client:____Date:_____________

Signature of Personal Representative:____