**PATIENT AUTHORISATION TO**

**RELEASE PERSONAL INFORMATION TO OTHER SOURCES**

|  |
| --- |
| I, please enter full name |
|  |
| of please enter full address |
|  |
| hereby authorise the Armadale Kalamunda Group to release personal information held by the agency pertaining to myself/my child enter child’s full name if necessary including the treatment received to: |
|  |
| Please insert the full name of the person to whom the information is to be released to |
|  |
| I also authorise the release of any information relating to this episode of care that may be held by another Health Care Facility or Practitioner. |
|  |
| Signature of patient/parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Date: Click here to enter a date |