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AUTHORIZATION FOR RELEASE FORM

|  |  |
| --- | --- |
| Name |  |
| Phone Number |  |
| Address |  |
| Date |  |

I understand that Victorian law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Victorian law and authorize the release of records of information, but only the extent specified below.

I authorize CRAMLI Counselling and Wellbeing Services to release and/or receive the following information concerning myself or my child:

|  |  |
| --- | --- |
|  | Case Notes |
|  | Educational Records |
|  | Progress Notes |
|  | Treatment Plans and Summary |
|  | Assessments and Reports |
|  | Any and All Records |
|  | Other: |

The above information is only to be released to, and/or from, the following party:

|  |  |
| --- | --- |
| Agency |  |
| Name |  |
| Phone Number |  |
| Title |  |

This information is to be used for the purpose of:

|  |
| --- |
|  |

This authorization shall remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at which time it shall expire, and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

I herby release the parties named above from any liabilities for release of this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Counsellor Date