haven therapy co

Consent to Release Information

Client Name: _____

Date of Birth: _____

I authorise Haven Therapy Co to:

☐ Share information with ☐ Obtain information from ☐ Exchange information with

Name of Person / Organisation:

Relationship / Role:

Contact Details:

Purpose of Information Sharing:

☐ GP Collaboration ☐ Care Coordination ☐ NDIS Support ☐ School / Educational Support ☐ Specialist Referral ☐ Family Involvement ☐ Other: _____

Information authorised for release:

☐ Attendance information ☐ Progress summaries ☐ Treatment goals ☐ Risk information where clinically relevant ☐ Reports / letters ☒ Other: _____

I understand that:

- I may withdraw this consent at any time in writing.
- Information disclosed may no longer be protected once received by the nominated third party.
- Only information relevant to the purpose above will be shared.

This consent remains valid until:

☐ A specified date: _____ ☐ I withdraw consent in writing

Client Signature: _____

Date: _____

Parent/Guardian Signature (if applicable): _____

Date: _____

Practitioner Signature: _____

Date: _____