RELEASE OF INFORMATION

GOLD COAST DBT
AUSTRALIAN DBT INSTITUTE
ABN: 15 645 970 896

RE: REQUEST/AUTHORISATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorise GOLD COAST DBT (6 Railway Street Southport QLD 4215; Ph: 07 5647 3438) to exchange information from clinical records about:

FIRST NAME		SURNAME:	
DOB			
HOME ADDRESS			

With

PERSON OR ORGANISATION	
ADDRESS	
PHONE	

For the following purpose(s):

- ☐ Further mental health evaluation, treatment or care
- ☐ Further planning
- ☐ Other: _____

The information to be disclose is marked by an X in the boxes below:

- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes, and treatment or closing summary
- ☐ Psychological and Psychiatric Reports
- ☐ Other: _____

I have had explained to me and fully understand this request/authorisation to release records and information, including the nature of the records, their contents, and the consequences and implication of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 12 months from the date on which it is signed, or upon fulfilment of the purposes stated above.

Signed……..…….. Date……..……

Name……..…….. **Client** **Parent** **Guardian**

Please circle one of the above to indicate your authority to request this release of information and/or records.