



CRISALIDA

CHILD, ADOLESCENT, ADULT & FAMILY THERAPY

678 High Street Thornbury 3071
630 Bell Street Preston West 3072
Phone: **9484 6299**
Fax: 9480 0838
e: admin@crisalida.com.au
w: www.crisalida.com.au

3A - INFORMED CONSENT FOR THE RELEASE OF INFORMATION FORM

At times during our work with individuals and families, it becomes helpful or necessary to share information with, and from, other practitioners. We will always discuss the reasons for this beforehand, and we also require your written consent.

I, _____, authorise the release and request of information
please print full name

regarding my history/my child _____'s history and treatment between
please print full name

_____ and third parties below for the purpose of improved service
Crisalida practitioner name

provisions by those individuals.

THIRD PARTY PRACTITIONERS

1. Name: _____

Clinic: _____

Phone: _____

Fax: _____

Email: _____

2. Name: _____

Clinic: _____

Phone: _____

Fax: _____

Email: _____

3. Name: _____

Clinic: _____

Phone: _____

Fax: _____

Email: _____

I acknowledge that I have read Crisalida's confidentiality agreement and give consent to the parties listed above to release and request information related to my history and treatment. I understand that this permission can be revoked at any time by myself in writing except for the information that has already been communicated.

please print full name

sign

date