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| **NEUROSCIENCES UNIT****Consent Form** | Med Rec. No: ………………………………………………..Surname: …………………………………………………….Forename: ……………………………………………………Sex: …………..……….. D.O.B. …………………………… |
| **CANAC AUTHORISATION TO RELEASE AND EXCHANGE INFORMATION** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of *(Address)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hereby, authorise professional staff employed at the Neurosciences Unit to release / obtain / exchange information (written and verbal) with other agencies and individuals in relation to *(Client’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Please tick one box below: [ ]  Yes, I consent to the release of information to agencies/people ticked below [ ]  No, I do not consent to the release of any information [ ]  Can I discuss with a Health Professional?

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| **Agency/Service Provider/Individual** *(Must specify name of service/provider in next column)* | **Specific details of service/provider and/or conditions of consent if required** |
| [ ]  Referring Service |  |
| [ ]  Paediatrician or other specialty medical provider |  |
| [ ]  General Practitioner (GP) |  |
| [ ]  School including teaching staff, principal, deputy principal and School Psychologist unless otherwise specified |  |
| [ ]  Psychologist/Mental Health Provider |  |
| [ ]  NDIS/Therapy Providers |  |
| [ ]  Other individuals (i.e. – other carers who may bring child to appointment, case managers, support workers, etc.) |  |

in relation to *(specify nature of information): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***I understand this information concerns personal affairs and is considered confidential.** **This authority expires one year from the date upon which it is signed.**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |