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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?   |  |  | | --- | --- | | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |