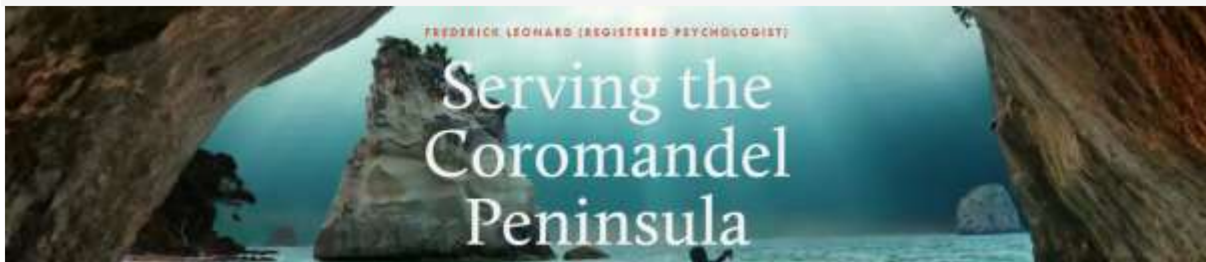
WHITIANGA PSYCHOLOGY



Authorization for release of private & confidential information

Name of referred person: ______________________________ DoB: __________

I, the undersigned, voluntarily request and authorize Whitianga Psychology to access from/release to the professional agency/individuals named underneath the mutually discussed information contained in my or my family's records.

I authorize Whitianga Psychology to release and/or obtain this private and confidential information verbally, in writing or electronically.

I understand that the purpose of releasing the nominated information may include sharing psychological information, intervention support planning, protection of self or others, coordinating professional interventions, educational planning.

I authorize Whitianga Psychology to release to/receive information from:

Name of Person/Agency	Contact Information (address, phone, email)

I agree to the exchange of the above nominated information. I have had an opportunity to ask questions regarding the professional exchange of this information. I understand that I have the right to revoke this authorization in writing addressed to Whitianga Psychology.

Name in print: ______________ Signature: _______________ Date: __________

Scan to: whitiangapsych@gmail.com **OR** Mail to: 16 Catherine Crescent, Whitianga, 3015