Outlook Psychology

Client Consent To Exchange Personal Information

Name Of Client: ____

As part of the assessment and therapy process, it is helpful for your Clinician to liaise with other people and agencies that are relevant to your therapy goals.

I give Outlook Psychology Practice consent to obtain from or provide information to the following stakeholders and health care professionals/agencies.

I understand that I can withdraw my consent at any time.

RELATIONSHIP	Y/N	NAME AND CONTACT DETAILS	IF APPLICABLE, SPECIFY LIMITATIONS
Next Of Kin			
Psychiatrist			
GP			
School			
Other (Please Specify)			

I acknowledge that I have read, understand and agree to the above information;

Name of Client (or guardian): ____________________________________

Signature of Client (or guardian): __________________________________

Date: ____