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RELEASE OF INFORMATION FORM

Client Information

Name: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Psychologist Information:

Name: _____

Practice Name: EMDR Brisbane

Address: 9/30 King St Bowen Hills QLD 4006

Recipient of the Information:

Provider's Name: _____

Organisation: _____

Address: _____

Authorisation:

I authorise _____ (psychologist) to share and release my health information as described to _____ (health provider) . This authorisation is valid for **ONE YEAR** from the date of signing unless revoked earlier. I understand that I may revoke this authorisation at any time by notifying the psychologist in writing, except to the extent that action has been taken in reliance on it.

Signature: _____

Date: _____/_____/_____