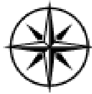

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AUTHORISATION FOR RELEASING & RECEIVING INFORMATION

I/We, [your name(s)]:

Give permission to [state name of your Mental Health Practitioner]:

To release and/or obtain information [attendance, goals, history, observations, treatment, recommendations]:

With the following person(s) or organisation(s):

Effective from the date below until the termination of our work together unless otherwise noted.

Date:

Client Signature(s):

Practitioner Signature: