AUTHORISATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ……………………………………………………………………… (Complete in block letters)

hereby give permission for …………………………………………………………………….
(for example: GP, therapist, ward manager, social worker, keyworker, CPN, psychiatrist)

To release information to …………………………………………… (Print name/s)

Their relationship to me is: …………………………………………………………………….
(for example, carers, friends, Mum, Dad, brother, sister, workmate)

Their address is: ……………………………………………………………………………...

………………………………………………………………………………………………..

Their telephone number is: ………………………………………………………………..

(Tick any of the boxes below that you want)

- ☐ About my condition and treatment
- ☐ About my medication and side effects
- ☐ About my care plan
- ☐ About individual therapy
- ☐ About group therapy
- ☐ About my discharge date
- ☐ About future appointments
- ☐ This authorisation is valid indefinitely
- ☐ This authorisation is only valid until …………………… (Review date)

Signature: …………………………………. Date: ………………

I have had the opportunity to discuss the issues with the above named person.

Signature by independent witness ……………………………………………………..

Date: …………………… Position: …………………………………………………..

Of address: …………………………………………………………………………….

Phone/Fax/E-mail: ………………………………………………………………….

Note: The independent witness should where possible be someone working in an advisory capacity such as a solicitor, advocacy worker, advice worker—someone not connected to Carers or mental health services.