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Tel: (03) 63272947
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CLIENT'S PERMISSION TO WINDSOR PSYCHOLOGY TO OBTAIN MEDICAL AND PERSONAL INFORMATION

Please read the following carefully and do not sign this consent form if you do not understand it or do not agree with its terms:

I ____ (Full name)

Parent /Legal Guardian /Carer of ____

Date of birth _______________________

Agree that the information I and/or my child provide/provided to ___________________________ during the course of my Child's (Name)____ medical or psychological assessment, treatment planning & on-going care and/or any other health, welfare or education services provided to my child by ____ can be shared with the following practitioner(s) at Windsor Psychology:

____
____
____
____

This permission is valid from ________________________to __________________________ (dates).

Signed: _________________________________

Name: __________________________________

Date: ___________________________________