



Windsor Psychology

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**CLIENT'S PERMISSION TO WINDSOR PSYCHOLOGY TO RELEASE
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 Windsor Psychology during the course of my Child's (Name) _____ psychological assessment, treatment planning & on-going care and/or any other health, welfare or education service provided to me by Windsor Psychology can be shared with:

This permission is valid from _____ to _____ (dates).

Signed: _____

Name: _____

Date: _____