



PBP CONSULTANCY

Committed to the provision of confidential professional counselling

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Prasanna Panditharatne

Registered Psychologist

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

Today's Date:

Patient's Name:

Date of Birth:

I authorize *Prasanna Panditharatne* to release and obtain healthcare information from:

Name:

Address:

Suburb: State: Post Code:

Name:

Address:

Suburb: State: Post Code:

This authorization applies to (PLEASE TICK):

Yes No ANY healthcare information to/from the person(s) listed above.

Yes No Only mental health information to/from the person(s) listed above.

Yes No MINIMUM healthcare information to maintain collaborative ties between healthcare professionals involved in my care.

I do not want the following information discussed with the person listed above:

Patient Signature:

Date Signed:

Psychologist's Signature:

Date Signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.