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**AUTHORITY TO OBTAIN AND/OR RELEASE INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client Name)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address)

Authorise Phoenix Support & Advocacy Service Inc. to exchange information with other relevant professionals or organisations.

This authority permits discussion between Phoenix and the parties mentioned below in addition to the exchange of written reports. This contact with other parties would be discussed with you prior, except in an emergency or if your safety and well-being are at risk.

I understand that I can change or cancel this authority at any time and can refuse to permit information exchange, except in the case of an emergency.

I understand that parties mentioned below will be provided with a copy of this authority before providing Phoenix with information.

I am being supported by (e.g. G.P, Case Worker, Drug & Alcohol counsellor). Please list the name and contact:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Phone Number | Address |
| General Practitioner |  |  |  |
| Support Worker |  |  |  |
| Counsellor |  |  |  |
| Psychologist |  |  |  |
| Psychiatrist |  |  |  |
| Mental Health Nurse  |  |  |  |
| Drug & Alcohol Counsellor |  |  |  |
| Other |  |  |  |
|  |  |  |  |

***OFFICE USE ONLY***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Phoenix Counsellor Signature***

***Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date