



CONSENT TO RELEASE INFORMATION

CLIENT INFORMATION

Full Name : _____
Date Of Birth : _____ / _____ / _____ Gender : Male Female
Address : _____
Mobile Numer : _____ Other Number : _____
Email : _____ Email 2 : _____

OBTAINING INFORMATION FROM OTHER AGENCIES

I consent to Pete Lewis Psychotherapy obtaining information from the agencies/individuals listed below, that is considered necessary and relevant to my psychological wellbeing and management. Examples of such information may include medical reports, mental health history, behavioural information, current difficulties, hearing/vision assessments and any other relevant allied health professionals' reports. This information will be used to better understand you, assist you, and assist with psychological treatment plans.

Name of Agency/ Individual	Contact Number	Email

RELEASING INFORMATION TO OTHER AGENCIES

I consent to Pete Lewis Psychotherapy releasing information to the agencies /individuals listed below, that is considered necessary and relevant to my psychological wellbeing and management. Examples of such information may include psychological reports, diagnoses, behavioural information, mental health history, current difficulties, and support strategies. The information shared will be that to further understand and assist you.

Name of Agency/ Individual	Contact Number	Email

NOTE: This authority is valid for twelve (12) months from the date signed.

Signature

Print your Name

Date

Clients under the age of 16 (Legal Guardian Authority)

Signature of Legal Guardian

Name of Child

Date

More Information :

📍 13 Harris Street, Camden Park NSW 2570

☎ 0451 653 545

🌐 info@petelewis.com.au

ABN: 66 251 108 707

THANK YOU

Withdrawal of Consent

(only use if wanting to withdraw permission to share information).

I, _____, withdraw my consent to share information with the above-mentioned agencies/ individuals.

Signature

Date