



Authority to release and collect information

CONFIDENTIAL

Name:

Halaxy ID:

Date of birth:

I.....

DOB.....

of (address):

.....

.....

.....

authorise my BlueHub clinician to access and release, in writing or verbally, any details of my health information to the specific agency or person named below.

The information must only relate to any history, treatment, and current health status which is relevant to psychological assessment, treatment, and participation in BlueHub.

I can notify my BlueHub clinician in writing if I no longer wish for them to liaise with the specific agency or person named below.

Specific agency/person to be given/receive health information:

Please tick:

**Release
to**

**Collect
from**

- Medical professional (e.g., GP, psychiatrist)
- Allied health professional (e.g., psychologist, social worker, OT)
- Wellbeing Services at Victoria Police or AFP
- TPAV or AFP Association
- Other.....
- Other.....

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Client name (person giving consent):

Client signature:

Date: