

## Third Party Release of Information - Consent Form

### Purpose of this Form

This form authorises **SANVT. Psychology** to exchange relevant information with the nominated third party/organisation.

Information will only be released where it is necessary for your care, with your consent, and in line with privacy legislation, the APS Code of Ethics, and the AHPRA Code of Conduct.

You may withdraw your consent at any time by notifying **SANVT. Psychology** in writing.

Once information is released, **SANVT. Psychology** cannot control how the third party uses or stores the information.

### Consent

I/We understand that this form authorises my/my child/my dependant's treating Psychologist / **SANVT. Psychology** to release and/or obtain information relevant to my and/or my child/dependent's psychological services to/from the third party/organisation named below.

I/We understand this consent can be withdrawn at any time by notifying **SANVT. Psychology** in writing.

1. I/We agree to the collection/release of information on behalf of (*full legal name*):

Myself: \_\_\_\_\_

My Child: \_\_\_\_\_

Other Dependant: \_\_\_\_\_

2. I/We give permission for my Psychologist/SANVT. Psychology to:

Request information from the person/organisation listed below

Provide information to the person/organisation listed below

Exchange information both ways (request and provide)

3. I/We agree to the collection/release of information to/from (*tick as many as apply*):

#### Family/Friends:

- Partner / Spouse
- Family Member(s)
- Friend(s) / Support Person
- Other (please specify)

#### Education/Work:

- School / Teacher(s) / Counsellor / Other
- University /Support Services / Other
- Work / Manager(s) / Other
- Other (please specify role)

**Health Services:**

- |                                                    |                                                             |
|----------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> General Practitioner      | <input type="checkbox"/> Other Specialist / Health Service  |
| <input type="checkbox"/> Psychiatrist              | <input type="checkbox"/> Insurance / Funding Service        |
| <input type="checkbox"/> Psychologist / Counsellor | <input type="checkbox"/> Case Manager / Support Coordinator |
| <input type="checkbox"/> Allied Health (OT, etc.)  | <input type="checkbox"/> Other (please specify role)        |

**4. Third Party Relevant Details:**

Please provide the following details for all people/services that apply in the text box below - Full name, relationship to you (e.g., friend) and Date of Birth (DOB), OR profession and name of service/organisation, contact email and/or phone:

- **Family/Friends example:**  
"Jane Smith, Friend, DOB:01/01/1990, jane@email.com, 0412 345 678."
- **Professionals/Services example:**  
*Example:* Dr L. Feelgood, Paediatrician, Feelgood Clinic, larry@email.com.

**5. Signature:**

Please sign here.

Your Name \_\_\_\_\_

Your Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Thank you for completing this form. Please return the completed and signed form to [hello@sanvt.com.au](mailto:hello@sanvt.com.au)