Government of **Western Australia**
Child and Adolescent Health Service

Consent for Release of Information
Child and Adolescent Health Service

Office Use only: Client UMRN – affix patient label here

Consent to obtain/ release/exchange information

I ____ *(Parent/legal guardian or mature minor full name)*

hereby authorise PCH clinical staff to obtain, release and exchange reports and relevant information (written and verbal) with other agencies and individuals in relation to

____ , ____

(Child's full name) *(Child's date of birth)*

Please tick one box below:

- ☐ Yes, I consent to the release of information to agencies/ people listed below
- ☐ No, I do not consent to the release of any information
- ☐ Can I discuss with a Health Professional?

Agency/Individual	**Specific details and/or conditions if required**
☐ Referrer (excluding referral via CAHS staff)	
☐ Day care	
☐ School : This may include teaching staff, principal and school psychologist unless otherwise specified	
☐ GP	
☐ Other professionals/agencies: This may include the National Disability Insurance Agency, their representatives and other community service providers	
☐ Other individuals, including those that may bring this child to appointments	

I understand that in certain circumstances the Child and Adolescent Health Services may be legally required to provide information in relation to this child to statutory bodies.
I understand that I may alter or withdraw consent at any time without prejudice.

Signature: ______________________________________ Date: ____________________________

Relationship to Child: ____

Consent Review (required annually)

Date	**Staff name**	**Signature** *(parent / guardian or mature minor)*	**Comment**