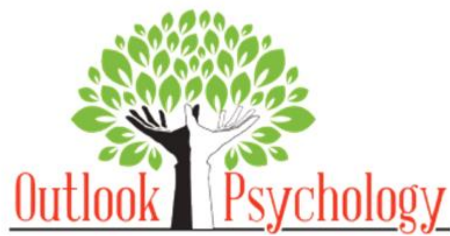

Client Consent to Exchange Personal Information
Child and Adolescent Client

Name of Client: ……

As part of the assessment and therapy process, it is helpful for your child's psychologist to liaise with other people or agencies that are relevant to your child's therapy goals.

I give Outlook Psychology my consent to obtain from or provide information to the following stakeholders and health care professionals/agencies.

I understand that I can withdraw my consent at any time.

Relationship	Y/N	Name and Contact Details	If applicable, specify Limitations
Next of Kin			
Psychiatrist			
GP			
School			
Other (please specify)			

I acknowledge that I have read, understand and agree to the above information:

Name of Client (or guardian): ………

Signature of Client (or guardian): ……………………………………………………………………………………………………

Date: ………………………….