FORM D

assure PROGRAMS

Authority for Release of Information

I ....
(Full Name)

of ....
(Full Address)

Hereby authorise ....
(Psychologist's name)

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from Assure Programs, to:

☐ **A. Obtain** information related to my

....

....

....
(circumstances)

and/or

☐ **B. Provide** information (to discuss or provide reports or clinical notes) related to my

....

....

....
(circumstances)

To ....
(Name)

of ....
(Organisation)

Signature: .... Date: / /