Radiance

Release of Information consent:

Name _____

Address _____

_____

Date of Birth _____

I ……..

Give consent for the Radiance Network Health professionals to give and receive information relating to: medical condition, treatment and care including provision of a copy of clinical notes and other documents forming part of my Health Record as well as other information held about me to the following persons/ organisations for the purpose of providing ongoing treatment, support, assistance and care.

The information to be released is in relation to my _____

Name_____

Address_____

_____

Date of Birth_____

Relationship to the person giving consent

_____

Name_____

Address _____

_____

Date of Birth_____

Relationship to the person giving consent

_____

Client Signature …… Date ……..

Radiance Health Professional Signature …… Date ……