Illawarra Shoalhaven Psychology

Release of Information Authority Form

For collaboration and communication purposes there are certain times when this service may need to communicate about you to another person who is involved in your care. In particular, if you are accessing this service under Worker's Compensation or Defence, there are requirements that information be sent to other treating parties e.g. the Doctor who referred you or your insurer.

In respect of your privacy and confidentiality we require your signed permission to proceed with any such communications and would ask that you consider the list of parties below, who we may have communication with. If there are any on the list that you would specifically **not** like this service to communicate with, please draw a line through that party.

- Referring Doctor
- Psychiatrist
- Insurer
- Rehabilitation Provider
- Other (please provide details): _____

Name: _____

Sign: _____

Date: _____

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