THE MIND FACULTY
Psychiatry & Psychology Medical Center

INFORMATION EXCHANGE CONSENT FORM

I (Name of *client/parent/guardian)** : _____

IC No / Passport no.* : _____

a parent / guardian of (*name client below 18 years old)* _____

authorize (Psychiatrist / Counselor / Psychologist / Therapist *name)* _____

to exchange information with *(Person's* name) _____

of (Company's/organization name, *if applicable, and address)* _____

_____

Regarding _____

for the purpose of _____

_____

"Please delete whichever not applicable

It is my understanding that information will only be exchanged with the person(s) listed above and that it remains valid within the whole process of therapy. I understand that I have the right to withdraw this consent by informing the therapist in writing at any time before the end of the process, but such withdrawal will not have effect on disclosures previously made with my consent. I have read and understood this authorization and I am signing it of my own free will.

Patient's Signature (Parent's / Guardian if patient is below 18 years old) Date :	**Psychiatrist / Counselor / Psychologist / Therapist** Signature Date :

Notes please discuss with your therapist if you are unsure of what is written in this document.

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