| PRINCESS ALEXANDRA HOSPITAL<br>HEALTH SERVICE DISTRICT<br>DIVISION OF MENTAL HEALTH | UR: _____<br>SURNAME: _____<br>GIVEN NAMES: _____<br>DATE OF BIRTH: ____/____/____<br>MALE ☐ FEMALE ☐<br>(Affix patient label here) |
|---|---|
| Queensland Government<br>Queensland Health<br><br>Transcultural Clinical Consultation Service,<br>Qld Transcultural Mental Health Centre<br>1800 188 189 | |

# CONSENT TO OBTAIN AND RELEASE INFORMATION

## TO WHOM IT MAY CONCERN

I give permission for the clinical staff of the Qld Transcultural Mental Health Centre to receive information from, and to provide the necessary information to other agencies/appropriate persons in order to assist with my assessment and treatment planning.

Exceptions (organization(s) and/ people that you do not expect the service to contact): ……

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Consumer Signature: …… Date: __/__/__

Print Consumer Name: ……

Staff Signature: …… Date: __/__/__

Designation: ……

Print Staff Name: ……

CONSENT TO RELEASE INFORMATION