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

Consumer Signature: _____ Date: __/__/___

Print Consumer Name: _____

Staff Signature: _____ Date: __/__/___

Designation: _____

Print Staff Name: _____

CONSENT TO RELEASE INFORMATION