Radiance

Supporting the emotional wellbeing of parents with their journey into parenthood

Release of information consent

Client name	
Address	
Date of birth	

I _____ give consent for the health professionals to give and receive information relating to my mental health and care as well as other information held about me to the Radiance Network South West Inc for the purpose of providing support and care.

The information to be released is in relation to my mental health only.

Health professional name	
Address	
Relationship to the person giving consent	

Client signature		Date
Health professional signature		Date