

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.

Research consent - applicable to Radiance Outreach Program only

I agree for the Radiance Participant Information and Evaluation Forms to be used for research purposes to support and improve our program. I understand that my personal information will be removed from the form before the responses are used for research.

Health professional name	
Address	
Relationship to the person giving consent	

Client signature	Date
Health professional signature	Date