



ecm

EDUCATIONAL CASE MANAGEMENT
CLINICAL ALLIED HEALTH SERVICES

SERVICING NEWCASTLE AND THE HUNTER VALLEY

Authority to Release Information

By signing the “*Authority to release information*” form, you are giving Educational Case Management Pty Ltd (ECM) consent to obtain relevant medical records, reports and/or statements from your treating medical practitioner, allied health professional and/or other professional persons involved in your care. The purpose of collecting this health information is to assist ECM practitioners in supporting you and determining ‘best practice’.

I
(FULL NAME OF PERSON) (DATE OF BIRTH)

Of
(ADDRESS)

Authorise the *release of information* to Educational Case Management.

Signed
(SIGNATURE OF PERSON AUTHORISING RELEASE OF INFORMATION)

.....
(SIGNATURE OF PARENT/CAREGIVER IF UNDER THE AGE OF 18)

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