

**INFORMATION RELEASE CONSENT FORM**

I, (or Parent/Legal Guardian on behalf of)

\_\_\_\_\_ born on \_\_\_\_\_  
(Name of Patient)

of \_\_\_\_\_  
(Address of Patient)

hereby authorise you to supply to

Vera Auerbach or \_\_\_\_\_  
Clinical Psychologist & Principal Associate

GyMEA Lily Psychotherapy Centre  
Suite 1, 17-21 Gray St, Sutherland, NSW 2232

information relating to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_