Information Request / Release Authorisation Form

Name of Patient: _____ Date of Birth: _____

Address:

_____

_____

I, _____, authorise Mr Raymond Ho at Enhancing Lives

Please tick:

☐ to request from my/my child's health information from

_____

_____

for the purpose of treatment planning.

☐ to release my/my child's health information to

_____

_____

for appropriate health management.

Patient		Parents (for minors)	
Signature:	_____	Signature:	_____
Name:	_____	Name:	_____
Date:	_____	Date:	_____