
RELEASE OF INFORMATION PERMISSION

I, *(insert parent's name)* _____, being the parent / legal guardian of *(insert child's name)* _____, hereby give permission to *(insert relevant name)*

Medical Practitioner _____

Allied Health Professional _____

Educational Professional _____

to release information of a clinical, diagnostic or academic nature relating to my above mentioned child, to

Dr Deberea Sherlock

SIGNATURE

DATE

WITNESS

DATE