**Authority to Release Information- Counselling Team**

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| I |  | (Name) |
| of |  | (Address) |

Client DOB:

**HEREBY AUTHORISE AND DIRECT** you to supply and/or discuss with the North Australian Aboriginal Family Legal Service Counselling Team (**NAAFLS**) any information including but not limited to statements, reports and records that I would be entitled to receive if I was to request such information myself.

I further authorise **NAAFLS** to release information about me to third parties when it is necessary to do so in order to carry out legal or client support work for me.

Understanding that electronic communications are not always secure, I further authorise NAAFLS counselling team to, in fulfilling the above duties, to communicate with any relevant persons/authorities by video conferencing, instant messaging, or electronic mail where appropriate.

I acknowledge a copy of this document provides the same authorisation as the original.

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| Client Name |  | Date |
| Client Signature |  |  |