

**South East Regional Substance Misuse Services
Consent of Release Information Under 18**

Name of Agency: Details:		
Name of Agency & person or individual to receive the information:		
Service User's Name:		
DOB:		
Name of Parent or Guardian:	Address:	Phone Number:
Purpose or need for the sharing information:		
What is the specific information to be released:		
Discussed with parent/guardian they right to revoke consent at any time?	Yes <input type="checkbox"/> No <input type="checkbox"/> Parent/guardian to tick they understand their right to revoke consent & Initial - <input type="checkbox"/> _____.	
Date, event, or condition upon which the consent will expire?	<input type="checkbox"/> 3 months <input type="checkbox"/> 6 Months <input type="checkbox"/> 3 months + Review for Re-consent Date for consent review _____ <input type="checkbox"/> 6 Months + Review for Re-consent Date for consent review _____ <input type="checkbox"/> Parent/guardian revoked consent – Date: _____	
Parent/guardian Signature & Date consent signed:		Date
Service User's Signature		Date
Staff Signature, Title & Date consent signed:		Date

***Only information that is necessary to accomplish the purpose stated in the form may be released.**