Family Matters Plus Counselling Services

AUTHORIZATION FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

_____ _____
Name of Person (print) Date of Birth

_____ _____
Name of Person (print) Date of Birth

Address _____ City/Town _____

Province _____ Postal Code _____

I/We, _____ hereby consent to

Information and/or reports being obtained	YES ( )	NO ( )
Information and/or reports being sent	YES ( )	NO ( )
Ongoing information exchanged	YES ( )	NO ( )

For the following Agency(s) / Professional(s)

_____

_____
Specify information to be released

_____

Duration of release of information _____

This information is to be used for the following purpose(s)

_____

_____

All information obtained will be kept confidential between the party(s) as specified above.
This release will be valid for a period of _____ (duration) from the date it is signed.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Counsellor's Signature Date

YOU MAY WITHDRAW YOUR CONSENT VERBALLY OR IN WRITING AT ANY TIME

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