Consent to Obtain/ Release Information

In order to share personal health information with others, we are required by federal and provincial legislation to obtain your consent. This measure protects your privacy and ensures only information you want to share will be shared.

Client Agreement Information

I, _____ **hereby provide consent for (please select below)**
(Print Full Name of Parent/Guardian)

- ☐ Audiology
- ☐ Massage Therapy
- ☐ Neurodevelopmental Physiotherapy
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Orthopaedic & Sports Physiotherapy
- ☐ Psychology
- ☐ Speech-Language Pathology
- ☐ Sports Medicine
- ☐ Other: _____

to **exchange information** about _____
Client's Name (Child's name)

Date of Birth: ____ / ____ / ____
(Day) (Month) (Year)

to the following individuals, programs and/or institutions:

☐ Obtain Date: _____
☐ Release Signature: _____

Notes: _____

☐ Obtain Date: _____
☐ Release Signature: _____

Notes: _____

☐ Obtain Date: _____
☐ Release Signature: _____

Notes: _____

☐ Obtain Date: _____
☐ Release Signature: _____

Notes: _____

☐ Obtain Date: _____
☐ Release Signature: _____

Notes: _____