Consent to Obtain/Release Information *(Caregiver/Guardian and Client)*

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 & Service Information

I, _____ **hereby provide consent for** ***(please select below)***

(Print Full Name of Caregiver/Guardian)

- ☐ Massage Therapy
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Physiotherapy
- ☐ Psychology
- ☐ Social Work
- ☐ Speech Therapy
- ☐ Other: _____

to exchange information about _____ Date of Birth ____ ____ ____

Client's Name (Child's Name) *Month* *Day* *Year*

Relationship to Client *(Child)* _____

to the following individuals, programs and/or institutions:

*Please check both **Obtain** and **Release** to ensure a two-way discussion between providers.*

Name _____ ☐ **Obtain Information**

Address _____ ☐ **Release Information**

Phone _____

Signature of Caregiver/Guardian _____ Date ____ ____ ____

Month *Day* *Year*

Signature of Client *(Child)* _____ Date ____ ____ ____

As Appropriate/12 Years or Older *Month* *Day* *Year*

Name _____ ☐ **Obtain Information**

Address _____ ☐ **Release Information**

Phone _____

Signature of Caregiver/Guardian _____ Date ____ ____ ____

Month *Day* *Year*

Signature of Client (Child) _____ Date ____ ____ ____

As Appropriate/12 Years or Older *Month* *Day* *Year*

Name _____ ☐ **Obtain Information**

Address _____ ☐ **Release Information**

Phone _____

Signature of Caregiver/Guardian _____ Date ____ ____ ____

Month *Day* *Year*

Signature of Client *(Child)* _____ Date ____ ____ ____

As Appropriate/12 Years or Older *Month* *Day* *Year*

Notes: