Consent to Obtain/Release Information *(Client Only)*

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 Client)

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

to exchange my information 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** ☐ **Release Information**

Address _____

Phone _____

Signature of Client _____ Date _____ *Month* _____ *Day* _____ *Year*

Name _____ ☐ **Obtain Information** ☐ **Release Information**

Address _____

Phone _____

Signature of Client _____ Date _____ *Month* _____ *Day* _____ *Year*

Name _____ ☐ **Obtain Information** ☐ **Release Information**

Address _____

Phone _____

Signature of Client _____ Date _____ *Month* _____ *Day* _____ *Year*

Name _____ ☐ **Obtain Information** ☐ **Release Information**

Address _____

Phone _____

Signature of Client _____ Date _____ *Month* _____ *Day* _____ *Year*

Notes: