Consent to Release Information

Client Name (Please print)____
First Last

Date of Birth: ____

I hereby authorize ____ (therapist) and:

____

____

to release any relevant personal/medical/treatment information about me with each other for the purpose of my care OR only the following information is to be released:

____

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Note: This waiver is in effect for one year from the date of the request.

Client Name: ___________________________________

Signature: ______________________________________ Date: ________________

Witness Name: __________________________________

Signature: ______________________________________ Date: ________________

The personal information collected on this form will be used for the purpose of processing your request to share your personal information as instructed above. It is collected under section 33 (c) of the Alberta Freedom of Information and Protection of Privacy Act, and will be protected under its provisions. If you have any questions about the collection and use of this information, contact Adele Fox.

A photocopy is as good as the original.