ERINOAKiDS
Centre for Treatment and Development

CONSENT FOR DISCLOSURE

I hereby authorize:_____
(Name of Person/Agency Releasing Information)

to release to _____

_____
(Name and Address of Person/Facility Requesting Information)

the following information (therapeutic, education, medical, psychosocial)

_____

_____
(Description of Information to be released)

from the records of:_____ _____
(Name of Client) (Date of Birth)

_____
(Address of Client)

I understand this information is to be used by the recipient for the purposes, of

- ☐ information sharing
- ☐ other _____

This consent allows both written and verbal communication. It can be withdrawn at any time by notification in writing.

_____ _____
Signature of Client /Legal Guardian/ Client Signature of Witness

_____ _____
Relationship to Client Date

Note: Authorization must be signed by the client if incapable, by the parent or legal guardian, whichever is the appropriate legal authority. In the case of a person who is physically or mentally disabled to such a degree as to be incapable of giving consent, the next-of-kin may authorize release of information.