

## ADULT RELEASE OF INFORMATION

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
 P.O. Box \_\_\_\_\_ Postal Code: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 Country of Residence: \_\_\_\_\_ City or District: \_\_\_\_\_  
 Phone: (H/O): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Please give us any special restrictions for leaving a message at the numbers provided:

do not leave a message OR  do not leave specific information regarding purpose

Preferred Email: \_\_\_\_\_

I authorize **The Wellness Centre Ltd.** to RELEASE and/or OBTAIN information in regards to the counselling, assessment, behavioural and/or psychological services ( affirms  deletes):

TO/FROM \_\_\_\_\_

NAME or ORGANIZATION / Relationship	EMAIL	NUMBER
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TO/FROM \_\_\_\_\_

NAME or ORGANIZATION / Relationship	EMAIL	NUMBER
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TO/FROM \_\_\_\_\_

NAME or ORGANIZATION / Relationship	EMAIL	NUMBER
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### Information released / obtained may include ( affirms denies):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Attendance            | <input type="checkbox"/> Medication Mgmt.          | <input type="checkbox"/> Medical Reports    |
| <input type="checkbox"/> Treatment Plan        | <input type="checkbox"/> Drug / Alcohol Testing    | <input type="checkbox"/> Legal Consultation |
| <input type="checkbox"/> Diagnosis/analysis    | <input type="checkbox"/> Work / School Performance | <input type="checkbox"/> Case Notes         |
| <input type="checkbox"/> Psychological reports | <input type="checkbox"/> Case Mgmt                 | <input type="checkbox"/> Other: _____       |

Please list any special instructions or delimitations for consent:

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By signing below, I understand that consent shall remain valid for the duration of services at The Wellness Centre and not longer than 90 days from the date of the last contact. I have been informed that I may revoke consent by written communication to The Wellness Centre at any time. If conjoint, both parties must consent to exchanging information and only one party is required to rescind this consent. I certify that this form has been fully explained to me and that I understand its contents.

Client Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_