CONSENT FOR EXCHANGE OF INFORMATION FOR MINORS

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

I/We authorize ***The Wellness Centre Ltd.*** to RELEASE and/or OBTAIN information in regards to the social, familial, educational, behavioural, and psychological services of the above named child;

(☑ affirms ☒ deletes):

☐ TO/FROM: _____ _____ _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____ _____ _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____ _____ _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐ TO/FROM: _____ _____ _____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

Information shared may include (☑ affirms ☒ denies):

☐ All clinical psychological and behavioural information – correspondence and documentation necessary for psychological treatment to be effective may be shared.

☐ Attendance information and correspondence regarding scheduling may be shared.

☐ Verbal reports on treatment progress and participation summaries may be shared.

Please list any special parameters or delimitations for this exchange: _____

By completing this form I (We) acknowledge that I have legal parental responsibility or have otherwise been delegated legal guardianship/parental responsibility. By signing below, I (We) 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 this consent by written communication to The Wellness Centre at any time. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____ _____

Guardian Name Signature Date (DD/MM/YY)

_____ _____ _____

Guardian Name Signature Date (DD/MM/YY)

_____ _____ _____

Witness Signature Date(DD/MM/YY)