Request for Disclosure of Health & Personal Information

I _____ authorize clinician(s) at Jim Freeman Psychotherapist Ltd. to disclose my healthy personal information to the following individual/organization(s)_____

_____

for the provision and coordination of treatment, and the safety of others.

_____ Attendance

_____Participation

_____Information relevant to enhancing treatment

_____Assessment and screening results for:

Family Violence

Addictions Screening

I understand why I have been asked to disclose my information and am aware of the risks and benefits of consenting or refusing to consent to the disclosure of my individually identifying information. I understand I may revoke this consent at any time.

Dated this:_____ of _____ , _____
(Day) (Month) (Year)

Expiry Date:_____ of _____ , _____
(Day) (Month) (Year)

Client Signature: _____

Witness: _____