ME First Wellness Professional Counselling

Request/Release of Information

RE: _____ DOB: _____

To Whom It May Concern:

[ ] I hereby authorize ME First Wellness Professional Counselling to release information about services rendered to the above-named, for the purpose of:

_____

[ ] I hereby authorize the ME First Wellness Professional Counselling to receive information about services rendered to the above-named from:

_____

for the purpose of _____

Such information may be transmitted under the conditions stated below, and/or as required by Federal or Provinicial staute or order of the court. This release will be effective for a period of ninety (90) days from the date signed below and will expire on _____

Information to be released/received may include

( ) Medical records ( ) Social/developmental

( ) Discharge summary

( ) Psychological evaluation

( ) Vocational evaluation/summary

( ) Treatment summary

( ) Psychiatric evaluation

( ) Educational record

( ) Substance abuse treatment history

( ) Social/developmental history

( ) Personal information including Social Insurance Number(s), address(es), and telephone No(s)

( ) Other

To the agency or professional person receiving this release:

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY PROVINICIAL LAW. PROVINCIAL REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT PRIOR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

THIS CONSENT TO RELEASE OF INFORMA TION CAN BE REVOKED AT THE WRITTEN REQUEST OF THE

PERSON WHO GAVE THE CONSENT.

I have read this form carefully and I understand what it means.

_____ ___ _____

Authorized Signature Date Staff Person Signature Date

I have read this carefully and I understand what it means and as I am not physically able to give my written consent, I am giving my verbal consent to release these records.

_____ _____

Witness Signature Date Staff Person Signature Date

_____

Witness Signature Date