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

☐TO/FROM ____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐TO/FROM ____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

Information released / obtained may include (☑ affirms ☒ denies):

☐ Attendance	☐ Medication Mgmt.	☐ Medical Reports
☐ Treatment Plan	☐ Drug / Alcohol Testing	☐ Legal Consultation
☐ Diagnosis/analysis	☐ Work / School Performance	☐ Case Notes
☐ Psychological reports	☐ Case Mgmt	☐ Other: __________________

Please list any special instructions or delimitations for consent:

____

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:_______________