

CONSENT TO DISCLOSE AND OBTAIN INFORMATION



Client Name:	Client ID:
Birth Date:	

I, _____ authorize *Open Doors for Lanark Children and Youth* to disclose and obtain information from my clinical record to the service or organization listed below **(12 years of age or older)**.

OR

I, _____ **(Parent/Guardian First/Last Name)**, am the parent or the authorized person to provide consent to disclose and obtain information for _____ **(Client's First/Last Name)**. I authorize *Open Doors for Lanark Children and Youth* to disclose and obtain information from _____ 's **(Client's First/Last Name)** clinical record to the service or organization listed below:

Organization/Service

Contact Person (if applicable)

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The information to be disclosed and obtained includes the following:

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I understand that:

- Information gathered will be treated confidentially and will be used for providing mental health services for my child and family or myself.
- I may revoke this consent at any time.

This consent is valid from _____ to _____ (date).

The above has been explained to my satisfaction and I understand by signing below:

Printed First/Last Name of
Parent/Guardian

Printed Name of Client 12 years of age and
older seeking **confidential** services

Signature of Parent/Guardian

Signature of Client 12 years of age and older
seeking **confidential** services

Witness Name (print First/Last name)

Printed Name of Client 12 years of age and
older seeking services

Witness Signature

Signature of Client 12 years of age and older
seeking services

Date of Signature

Date of Signature