Consent for Disclosure of Personal/Medical Information

I _____
(Participant name or Legal Guardian)

Of_____
Streets address City Prov. Postal Code

Hereby consent to the disclosure of personal information to:

_____
(Facility Requesting Information, i.e. Creating Alternatives)

From the records of _____
(Name of facility providing records, i.e. doctor)

In respect of _____ Date of birth _____
(Name of individual) (dd/mm/yy)

I understand that the information obtained by this form will **only** be used by Alternatives for the purposes of coordinating appropriate services for the above individual.

Witness: _____ Signed by: _____

_____
(If other than the individual state relationship)

Dated: _____ Date consent expires (1 year): _____
(dd/mm/yy)