Counselling Services of Belleville and District | *Pathways For Children and Youth* | *Lanark Community Programs*

Collaborative Access Process to Service

Southeast Regional Autism Program

Common Consent to Share Information

Release of Information

I _____ of _____
Surname *Given Name* *Address* Postal Code

Hereby consent in the sharing of information ☐ To ☐ From the following

_____
Name of Agency, Facility or Private Practitioner

_____
Name of Agency, Facility or Private Practitioner

_____
Name of Agency, Facility or Private Practitioner

_____
Name of Agency, Facility or Private Practitioner

In respect of _____ _____
Name Date of Birth (DDMMYY)

For the purposes of the admission, referral and eligibility review process of the Southeast Regional Autism Program the following information:

☐ All Pertinent information
☐ Specifically the following information:_____
_____
_____

this consent is valid for the following period ☐ One year from signing date
☐ _____ (specify time frame) from signing date

I understand that I may revoke this consent in writing at any time.

_____ _____
Signature Date

_____ _____
Witness Date