



CONSENT TO RELEASE/OBTAIN INFORMATION

I. _____, of _____, d.o.b.: _____ and/or
parent/legal guardian/substitute decision maker child/youth/individual

_____, hereby consent to _____ **LHCC** _____
child/youth/individual program/service provided by R.E.A.C.H.

OBTAINING from Regional Municipality of H-N Social services _____ the following information:
name of agency/department, district school board, hospital etc.

RELEASING to _____ Regional Municipality of H-N Social services _____ the following information:
name of agency/department, district school board, hospital, etc.)

	Obtain (✓)	Release (✓)		Obtain (✓)	Release (✓)
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	Youth Justice	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Health	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Audiological	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive/Educational/Achievement	<input type="checkbox"/>	<input type="checkbox"/>
Physical/Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Optometric/Ophthalmological	<input type="checkbox"/>	<input type="checkbox"/>
Social Work	<input type="checkbox"/>	<input type="checkbox"/>	Behavioural	<input type="checkbox"/>	<input type="checkbox"/>
Speech and Language	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial/Clinical/In-Home	<input type="checkbox"/>	<input type="checkbox"/>
IPRC/IEP (most recent)	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Screening	<input type="checkbox"/>	<input type="checkbox"/>
Child Welfare	<input type="checkbox"/>	<input type="checkbox"/>	Crisis Intervention	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____ Subsidy _____				<input type="checkbox"/>	<input type="checkbox"/>
	please specify information requested/released				

for the purpose of: service/program delivery
case/service coordination
application for funding of other services
other: _____

Often ongoing communication between services providers and other agencies is necessary so we may work together to coordinate services and develop plans to meet the individual's needs. Communication may be in verbal or written form.

I/we consent to ongoing communication Yes No

Consenting Person Consenting Person Consenting Person

Witness Date

This consent is valid for one year, or when service has ended (if earlier). Consent can be withdrawn at any time.

Consent Withdrawn _____ Date: _____
signature

(see over for renewals of consent)

Renewal 1:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 2:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 3:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 4:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 5:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 6:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	

Renewal 7:

_____	_____	_____
Consenting Person	Consenting Person	Consenting Person
_____	_____	
Witness	Date	