Children's Mental Health of Leeds & Grenville

CONSENT TO RELEASE and OBTAIN INFORMATION

This consent is on behalf of , born on and Client ID# .

I **,** give permission for Children's Mental Health of Leeds & Grenville to obtain and release information from my clinical record to the initialed services and organizations listed below.
Or
I, am the parent or an authorized person to provide consent to release and obtain information for my child. I give permission for Children's Mental Health of Leeds & Grenville to obtain and release information from child/youth's clinical record to the initialed services and organizations listed below.

Initial	Organization/Service	Contact
	Family Physician	
	School	
	Family & Children's Services of Lanark, Leeds & Grenville	
	Child & Adolescent Psychiatry, at Hotel Dieu Hospital and/or Kingston General Hospital including Patient Records	
	Children's Hospital of Eastern Ontario	
	Other: (Please list)	

The information to be obtained and shared will include information relevant to my ongoing service with CMHLG.

Exceptions to information that can be shared includes the following:

I understand that:
a) Information gathered will be treated confidentially and will be used for providing mental health services for my child and family and
b) I may revoke this consent at any time.

This consent is valid from (month/day/year) __________________ to the end of service.

The above has been explained to my satisfaction and I understand.

____ _____________________
Client Full Name (First, Middle and Last Name) Date

____ _____________________
Parent or Authorized Person Providing Consent Date

____ _____________________
Worker Date