Howard & Associates

Psychological Services

Authorization to Disclose Information

I, _____,
(print name in full)

of _____,
(full address)

consent to the exchange of information between _____ _____
(Counsellor's name)

and _____ _____
(name of organization, agency or individual)

I understand that any such professional consultation will be to assess my needs or those of my dependent, as well as to assist in initiation, coordination and follow-up on any counseling plan that may be formulated. I understand that any discussion or documentation exchanged will be held in confidence by both parties and will become part of the Clinical Record.

The Authorization to Disclose Information will expire 90 days following the date on which it is obtained. The client may verbally withdraw this authorization at any time prior to the expiration date.

_____ _____
Client's Signature (or parent/guardian's signature) Date

_____ _____
Witness Date