HEALTH-CONNECT
COUNSELLING PARTNERS

CONSENT

Informed Consent for the Examination, Disclosure, Transmittal, and/or Communication of Information in a Clinical Record/File.

I: _____ born on: _____

(Client's Name) (DOB: DD/MM/YYYY)

hereby consent to the examination, disclosure, transmittal (by fax) and/or communication of information compiled.

Between: **Health-Connect Counselling Partners** And
the party (e.g. doctor, agency, etc.) named below

_____
(Name of doctor, agency, etc.)

For the purpose of: _____

This Authorization is effective from: _____ to _____
(date: DD/MM/YYYY) (date: DD/MM/YYYY)

This consent may be withdrawn or amended (changed) at any time prior to the expiration date, except on action(s) already taken on the authority of the consent.

_____
(Signature of Client 12 years or older) (Date: DD/MM/YYY)

_____
(Signature of Counsellor) (Date: DD/MM/YYY)