CONSENT
(Minor Child)

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

I/We: ______________________ and ______________________
(Parent/Guardian's Name) (Parent/Guardian's Name)

hereby consent to the examination, disclosure, transmittal (by fax) and/or communication of information compiled with respect to the minor child named below:

______________________ Born on: ______________
(Minor Child's Name) (DOB: DD/MM/YYYY)

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This consent may be withdrawn or amended (changed) at any time prior to the expiration date, except on action(s) already taken on the authority of the consent.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 Parent/Guardian) (Date: DD/MM/YYY)

______________________________ ______________
(Signature of Parent/Guardian) (Date: DD/MM/YYY)

______________________________ ______________
(Signature of Witness) (Date: DD/MM/YYY)