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CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF CLINICAL INFORMATION

I, _____
(print full name of person)

of _____
(address)

hereby consent to the disclosure or transmittal to, or examination by

NAME: _____

of the clinical information compiled in/by _____
(name of clinician)

(address)

in respect of _____
(name of client and date of birth)

I request that you forward the following information from the record:
(Please initial below)

- _____ Referral/Consultation Letter
- _____ Ongoing case consultation as required

(Date)

(Signature of client)

(Signature of Spouse, Parent Guardian or next of kin)

(Relationship to Client)

(Signature of Witness)

(Print Witness Name)