POLO
HEALTH + LONGEVITY CENTRE

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION FORM

This form provides your counsellor with written permission to communicate with other individual providers regarding your treatment (e.g., previous treating therapist, current health care providers, parents or school).

Client Name(s): _____

Client Date of Birth: _____

I authorize my counsellor, Autumn Stepanyants, RCC #19849, to release/exchange information for the coordination of my care to the person or party listed below.

Name: _____

Occupation or Relationship: _____

Phone: _____

Email: _____

This release will be valid until the termination of treatment or authorization from the client or parent/guardian to revoke

Expiration date (if applicable):

This authorization may be revoked at any time.

Name of client or parent/guardian (print):

_____

Signature of client or parent/guardian:

_____Date: _____