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IMPORTANT

impressions inc. Family Counselling Services

Consent to Release Medical Information

Pursuant to the Personal Health Information Protection Act, 2004

I, the undersigned patient, hereby authorize ***IMPRESSIONS* Family Counselling Services**, and its representatives, to release/disclose ***and/or*** receive/accept my personal health information consisting of:

clinical notes, assessment records and results, diagnosis and treatment plan(s), consultation reports, progress reports and,

other: *please specify* all other associated records which constitute health services delivery provisions.

as deemed necessary and/or appropriate for the assessment, provisions and/or maintenance of health-related services.

with the following individual/organization/entity:

Organization Name	*Contact Person*	*Relationship to Patient*	*Contact Phone No.*

PATIENT SURNAME	FIRST NAME	DATE OF BIRTH (DD/MM/YYYY)	
HOME ADDRESS		**HOME PHONE NUMBER (optional)**	
CITY		**PROVINCE**	**POSTAL CODE**

Acknowledgement and Consent Statement

I consent and authorize my attending Mental Health Therapist who has records, knowledge or information regarding my health/medical conditions to release and/ or receive such health/medical records/information to the individual/organization/ entity identifed above for the purposes stated.

I understand why I have been asked to authorize the disclosure of this information, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

Effective Date: This consent will be valid for one year from this date:

YYYY MM DD

Craig Maguire

Therapist Name (please print)

IMPRESSIONS Family Counselling Services Inc.

NAME OF FACILITY/CLINIC OR ADDRESS

(866) 708-3501

PHONE NUMBER (if available)

Signature of patient, or representative, if patient is incapable of signing or making a personal decision.

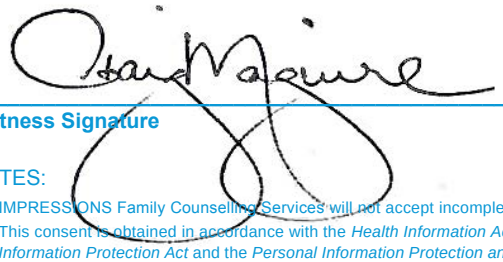
Representative: If signed by representative, describe the relationship or authority (for example parent, spouse, legal guardian, personal directive, power of attorney)

Name of person signing above (please print)

Name of representative signing above (please print)

CRAIG MAGUIRE

Witness Name (please print)



Witness Signature

RETURN TO: IMPRESSIONS Family Counselling Services Inc.
P.O. Box 27002
Victoria, BC
V9B 5S4

https://www.impressions-counselling.org/services

NOTES:

- IMPRESSIONS Family Counselling Services will not accept incomplete consent forms.
- This consent is obtained in accordance with the *Health Information Act*, *Personal Information Protection Act* and the *Personal Information Protection and Electronic Documents Act (Canada)*.
- I understand I may revoke my consent at anytime but should I do so, this Agreement is immediately terminated.
- A separate consent form is mandatory for each contact required.