Extended Therapy Services

4325 Neill Street
Port Alberni, B.C. V9Y 1E5
Fax: 250-723-7349
Phone: 250-723-1117

CONSENT TO OBTAIN AND RELEASE INFORMATION

I, the undersigned parent/legal guardian of _____

Date of Birth (dd-mmm-yyyy) do hereby authorize:

☐ Occupational Therapy

☐ Physiotherapy

☐ Early Childhood Mental Health

To obtain and/or release verbal and written information with the following:

(please check each column as appropriate)

OBTAIN	RELEASE	AGENCY (provide contact name)	DATE
		Parents by ☐ Address ☐ Telephone ☐ Text ☐ Email	
		Ministry of Children and Family Development	
		USMA Family & Child Services	
		Foster Parents by ☐ Address ☐ Telephone ☐ Text ☐ Email	
		Early Childhood Mental Health	
		Speech & Language Pathology	
		Early Years Outreach (NTC)	
		Infant Dev. (PAACL)	
		Supported Child Dev. (PAACL)	
		Family Physician	
		Paediatrician	
		Other Doctors:	
		Daycare/Preschool Program	
		School District 70	
		Audiology	
		Orthotist	
		Public Health Nursing (Island Health)	
		Public Health Nursing (NTC)	
		Family Support (Island Health)	
		Family Support (Friendship Centre)	
		Other:	

Name of Parent / Legal Guardian (please print)

Relationship to Child

Signature of Parent / Legal Guardian

Date

Name of Witness /Clinician (please print)

Signature of Witness /Clinician

Consent Type (choose one): By email

Note: This consent expires in one year, upon discharge from service or if guardianship changes.